Exhibit C

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	: SUPERIOR COURT OF
	: NEW JERSEY
IN RE:	: LAW DIVISION -
PELVIC MESH/GYNECARE	: ATLANTIC COUNTY
LITIGATION	:
	: MASTER CASE 6341-10
(GENERAL, GROSS, WICKER)	:
	: CASE NO. 291 CT

CONFIDENTIAL-SUBJECT TO STIPULATION AND ORDER OF CONFIDENTIALITY

- - -

Tuesday, November 6, 2012

VOLUME II

- - -

Transcript of the continued deposition of ANNE M. WEBER, M.D., M.S., called for examination in the above-captioned matter, said deposition taken pursuant to Superior Court Rules of Practice and Procedure by and before Kimberly A. Overwise, a Certified Realtime Reporter, Registered Professional Reporter, Certified Court Reporter, and Notary Public, at Mazie, Slater, Katz & Freeman, 103 Eisenhower Parkway, 2nd Floor, Roseland, New Jersey, on the above date, beginning at 9:45 a.m.

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I N D E X

E X H I B I T S
(Attached.)

DEPOSITION SUPPORT INDEX
- - -

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CONFIDENTIAL DESIGNATION INDEX

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...ANNE M. WEBER, M.D., M.S., after having been duly sworn, was examined and testified as follows:

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EXAMINATION

BY MS. JONES:

Q Doctor, as we mentioned yesterday and as you know, you have submitted in this litigation voluminous reports with your opinions that include what I'll call a general report and then case-specific reports for Ms. Gross and Ms. Wicker; correct?

A Correct.

Q And you have since supplemented with some additional reports after you have read or reviewed additional materials; am I correct?

A Correct.

Q And we were furnished last Friday or over the weekend with an updated list of materials that you had reviewed. And with the exception of Dr. Lucente's deposition, which was taken on Friday, I assume that that list is correct and complete to the best of your knowledge?

A Yes.

Q Are all of your opinions that you intend

to offer at the trial set forth in the reports that you have prepared?

A Yes.

Q Do you anticipate any additional work specifically with respect to Ms. Gross or Ms. Wicker?

MR. SLATER: Objection.

You can answer.

THE WITNESS: I think that depends on what's produced between now and trial.

BY MS. JONES:

Q Let me clarify. I understand you may review some additional depositions or documents, but have you requested, for example, any materials on either of those patients that you wish to review that you've not yet had an opportunity to review?

A No.

Q Have you requested an opportunity to examine either of those women?

A No.

Q Have you requested an opportunity to visit with either of those women?

A No.

Q I take it that you are comfortable arriving at your opinions with respect to those

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women based upon the contents of the medical records and the depositions that you've reviewed?
A And the reports.
Q And what reports?
A The reports from the people who have examined them.
Q Those who have examined them specifically for purposes of this litigation?
A Yes.
Q Do you have any criticisms of the treating surgeons or doctors who implanted the Prolift®s in either Ms. Gross or Ms. Wicker?
A No.
Q Do you believe and is it your opinion that each of those women was an appropriate candidate for the use of Prolift®?
A I do not agree.
Q Well, let me see if I can separate these out. Is it your judgment that it is a breach of the standard of care for a doctor to use Prolift® in any woman?
A I wouldn't call it a breach of the standard of care. I would call it a deception on the part of Ethicon when they illegally marketed the Prolift® and did not notify physicians and patients

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that was the case. Physicians were assuming they were using a properly FDA-cleared device and that was untrue.
MS. JONES: Move to strike as nonresponsive.
BY MS. JONES:
Q Doctor, in terms of whether or not the device was legally marketed, are you aware of the guidances that recognize that certain devices do not require 510(k) clearance prior to marketing?
A I am aware.
Q Has the FDA ever begun, to your knowledge, any type of enforcement proceedings against Ethicon with respect to Prolift®?
A The FDA informed Ethicon that it could not market Prolift® until the clearance process was completed, and Ethicon did that anyway.
MS. JONES: Move to strike as nonresponsive.
BY MS. JONES:
Q My question, Doctor, was: Has the FDA ever initiated any enforcement proceedings against Ethicon with respect to the marketing of Prolift®?
A No.
Q Has the FDA ever declared Prolift®

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misbranded in any way?
MR. SLATER: To her knowledge?
THE WITNESS: Not to my knowledge.
BY MS. JONES:
Q The FDA did clear Gynemesh® PS, did it not?
A Yes, it did.
Q That was in 2002?
A Yes.
Q The mesh in Prolift® is identical to that mesh?
A Yes. Excuse me. The mesh in Prolift® was cut by a different method, it was not identical.
Q I'm sorry. It was not what?
A It was not identical.
Q It was in a different shape; correct?
A It was cut by a different method.
Q It was also in a different shape, was it not?
A Correct, it was in a different shape.
Q And Gynemesh® PS was modified and cut by surgeons in order to use it transvaginally, was it not?
A Correct.
Q Mesh has been used and cut to be used in

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transvaginal surgeries since the 1990s, has it not?
MR. SLATER: You're talking mesh in general; right?
MS. JONES: Uh-huh.
THE WITNESS: Correct.
BY MS. JONES:
Q And that mesh in general was cut and used to be used transvaginally by surgeons without FDA clearance for use in that manner; correct?
A That's an entirely different situation. Off-label use by physicians is allowable. Illegal marketing by a company is not.
MS. JONES: Let's just move to strike as nonresponsive.
BY MS. JONES:
Q Can you answer my question, Doctor?
MS. JONES: Do you want to read back my question.
MR. SLATER: She probably thinks she did answer the question, as I do.
You understand when she moves to strike, she's preserving her rights for the future. It doesn't mean that your testimony is actually going to be stricken because I'm obviously going to oppose those motions. I just want you to know

procedurally what she's doing. She's just preserving her rights. It's perfectly fine to move to strike.

THE WITNESS: Okay. Could you repeat the question, please?

(The court reporter read the record as follows:

"QUESTION: And that mesh in general was cut and used to be used transvaginally by surgeons without FDA clearance for use in that manner; correct?")

THE WITNESS: Correct. I'd like to expand on that.

MR. SLATER: You can.

THE WITNESS: The off-label use by physicians of a material or a drug is allowable. Illegal marketing of a commercial product without FDA clearance is not.

BY MS. JONES:

Q Would you identify for me one place, Doctor, just one place, where the FDA has ever suggested that Ethicon illegally marketed Prolift®?

A In the letters -- in the process -- in the interaction between FDA and Ethicon, the letter stated you may not market this device while this

process of clearance is ongoing.

Q Have you ever spoken with anyone at the FDA about that?

A No.

Q Have you ever seen, Doctor, anywhere in writing anyplace where the FDA said we consider that Ethicon illegally marketed the device?

A FDA determined, when they finally realized Prolift® was on the market, that it required a separate application for clearance.

MS. JONES: Move to strike as nonresponsive.

BY MS. JONES:

Q My question, Doctor, was: Have you ever seen anyplace where the FDA said specifically we consider that Prolift® was illegally marketed?

MR. SLATER: You mean where those exact words were used?

MS. JONES: That's exactly what I'm asking.

THE WITNESS: No.

BY MS. JONES:

Q When surgeons began using mesh for transvaginal surgery in the 1990s, they used tools to place that mesh, did they not?

A Yes.

Q You use tools when you do abdominal surgery, do you not?

A Yes.

Q You use tools when you do any type of Prolift® surgery, don't you?

A Yes.

Q In terms of --

A I'd like to expand on that, if I may. You use tools that the hospital buys and the surgeon may request that are also used for other procedures. The tools in the Prolift® procedure were developed for use for the Prolift® procedure and only the Prolift® procedure.

Q Those tools were developed by surgeons, weren't they?

A No. They were developed by Ethicon.

Q You don't think that they were developed working with surgeons?

A They were developed working with surgeons.

Q And that surgeons use those tools?

MR. SLATER: Is that a question?

MS. JONES: That is a question.

THE WITNESS: They only use those tools because Prolift® is made available as a kit.

BY MS. JONES:

Q Those tools were used by surgeons before it was marketed as a kit, were they not?

A No.

Q Never?

A No.

Q That's your testimony?

A Yes, it is.

Q Have you ever used any of the Prolift® tools?

A No.

Q Prior to being engaged in this litigation, did you ever see any of those Prolift® tools?

A No.

Q If we go back to your testimony with respect to Ms. Gross and Ms. Wicker, am I correct that you testified that you have no criticisms of the implanting surgeons?

A The surgeons followed the standard procedure of Prolift® implantation. My criticism is of the Prolift® procedure and mesh implantation.

Q My question, Doctor, was as follows: Do you have any criticism whatsoever of the doctors who chose to use Prolift® in Ms. Gross and Ms. Wicker?

A No, I do not.

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Q If we go back to the appropriate treatments for prolapse, I think you identified three different classes of treatment, if you will. One is observational, just watching, if the patient seems to be asymptomatic; correct?
A Technically observation is not a form of treatment.
Q If a woman has prolapse but seems to be asymptomatic, is it appropriate to observe and delay any treatment?
A Yes.
Q Other therapies that are available would be exercises, as we've discussed, correct --
A Yes.
Q -- pelvic floor exercises? And the use of pessaries; correct?
A Correct. And also behavioral and lifestyle changes.
Q In terms of pessaries, the pessaries are not suitable for treatment for every woman's prolapse, are they?
A No, they are not.
Q And, indeed, pessaries may be difficult for some women to use; is that right?
A That is correct.

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Q Oftentimes it may be that a woman has to visit her doctor three or four times a year in order to have the pessary removed and cleaned and to consult with a doctor; correct?
A Correct.
Q Pessaries generally have to be removed before sexual intercourse; correct?
A No.
Q There are those who recommend removal before sexual intercourse, do they not?
A Are you speaking of physicians?
Q Yes.
A I can't speak to what all other physicians would recommend.
Q Have you seen it reported in the literature that one of the issues with the pessary use is that it should be generally removed for sexual intercourse?
A No.
Q Have you seen it reported in the literature that pessaries may be associated with vaginal discharge?
A Yes.
Q Odor?
A Yes.

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Q Ulceration?
A Yes.
Q Bleeding?
A Very uncommonly.
Q And then if you're going to look at the surgical treatments or therapies for prolapse, you have vaginal approaches, abdominal approaches, laparoscopic approaches, and robotic approaches; correct?
A Laparoscopic approaches are abdominal approaches. Robotic approaches are a subset of laparoscopic approaches.
Q Have you ever done laparoscopic surgery for prolapse?
A No.
Q Have you ever done robotic surgery for prolapse?
A I am going to correct that last statement. I have performed paravaginal repairs laparoscopically.
Q On how many occasions?
A Perhaps 20 to 30.
Q Have you ever performed robotic surgery?
A No.
Q If one is evaluating the surgical

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treatment for prolapse, one of the considerations is the type and severity of the prolapse that the woman has?
A Yes.
Q The surgeon's training and experience?
A Yes.
Q The patient's preference for the type of surgery after consultation with the physician?
A Yes.
Q And obviously the desired outcome; correct?
A Yes.
Q For example, one of the surgeries that can be performed for prolapse is obliterative surgery that closes the vagina; correct?
A Correct.
Q And that would obviously be appropriate generally only for those who don't seek to have intercourse in the future?
A Correct.
Q When surgeons perform the surgeries, they often choose different techniques in performing the same surgeries, do they not?
MR. SLATER: Objection.
You can answer.

THE WITNESS: There are standard techniques of performing surgeries that surgeons may vary.
BY MS. JONES:
Q And the surgeons vary based upon either different approaches and what they feel comfortable with or what they find to be satisfactory?
A Correct.
Q And as surgeons they may vary approaches in the sense of being innovative in order to provide better care to their patients?
A That is a complicated answer because the line between innovation and experimentation is not black and white.
Q Well, innovative approaches over time have led to better healthcare in general, have they not?
A No, I wouldn't agree with that in general.
Q Would you agree that all surgeries have risks?
A Yes.
Q That even in the absolute best of hands a surgeon that there are complications that may not be avoided?
A Yes.
Q If we talk about Ms. Gross, Ms. Gross had

had prior surgeries before she had the surgery involving Prolift®, had she not?
A Correct.
Q Had some recurrent prolapse?
A She did not have recurrent prolapse.
Q She'd had a hysterectomy before?
A Correct.
Q That's one of the issues that you consider when you determine what surgery would be appropriate?
A I don't understand your question.
Q Is it appropriate to consider what prior surgeries a patient has had before you determine what surgery to perform to correct the prolapse?
A Of course, that's part of the patient's history. I don't know that that necessarily modifies the surgical approach to her current prolapse problem.
Q Let me just ask you this: What options would you have considered as Ms. Gross' surgeon to correct her problems in 2006?
A Based on my understanding of her condition at that time, with a Grade 3 to 4 rectocele and an enterocele above that, I would have considered a rectocele repair, a posterior colporrhaphy. If I

determined that she needed an apical prolapse procedure, I would have considered an iliococcygeal muscle repair, possibly a uterosacral ligament suspension; and if I decided she needed it, which would probably be an intraoperative decision, an enterocele repair.
Q How would you have counseled Ms. Gross in advance of the surgery in terms of what her options for treatment were?
A As we discussed, I would go over behavioral and lifestyle changes, pelvic muscle exercises, pessary use, and surgery.
Q And do you understand that all of those were discussed with Ms. Gross?
A My recollection from the records is that a pessary was discussed. I don't recall the behavioral and lifestyle changes and exercises.
Q Do you recall that Ms. Gross was not interested in a pessary?
A I recall that in the discussion with her physician he was not enthusiastic it would be a good solution for her. And in her experience she also preferred not to choose a pessary.
Q What would you have discussed with Ms. Gross about her surgical options?

A I would have discussed the procedures I named before and that at least part of the decision would be based on the intraoperative findings.
Q And what would you have told her were the complications associated with the surgery?
A As we discussed yesterday, the general risks of any surgery: Bleeding, infection, risk of anesthesia, complications that aren't directly related to the surgical site but occur postoperatively, like blood clots, pneumonia.
And then specific to the surgery, after surgery pain with intercourse, voiding dysfunction. I would mention the risk of ureteral injury since a possibility would be uterosacral ligament suspension, other organ injury that may need other surgery to repair it. That's all I can think of at the moment.
Q Would you discuss with her risk of damage to the pudendal nerve?
A Nerve damage. I consider in the organ tissue damage category nerve damage. I would only specifically mention that if I were considering a sacrospinous ligament fixation.
Q What would you have told her about the possibility of recurrence?

A That these operations aren't perfect, we can't obviously guarantee 100 percent success, and that there's a possibility that her problem could come back.
Q And, in fact, about 30 percent of all prolapse surgeries are for recurrence, aren't they?
A I don't think that's a reliable number.
Q That's certainly --
A That's from one study.
Q That number's certainly been reported, has it not?
A It's been reported to death.
Q And there have been different studies which have reported recurrence rates as high and in excess of 50 percent; correct?
A Recurrence, again, is a definition that's undergone modification. At a time in the past when anatomic outcomes were the focus, patients were labeled as having recurrent prolapse when it passed a certain arbitrary point in the POP-Q system. Many of those women are asymptomatic, they don't need subsequent surgery, they go on about their lives.
Q My question was, Doctor: Rates of recurrence in excess of 50 percent have been reported, have they not?

A Correct.
Q Those have been reported out of the Cleveland Clinic; correct?
A Correct.
Q Those were reported out of the Cleveland Clinic when you were there; correct?
A It was certainly a study I co-authored. I don't remember exactly when that was published, if I had left the Cleveland Clinic by then.
Q But the patients in the study, patients were treated and the study was conducted while you were at the Cleveland Clinic?
A Correct.
Q You are aware, are you not, that the FDA premarket notification process prior to 2005 did not require original clinical studies to support the clearance of surgical mesh; correct?
A Correct.
Q In the course of looking at and reviewing these records, have you looked at any clinical data that was used to support the clearance of the AMS products Apogee® or Perigee®?
A Not specifically, no.
Q Had you ever looked at any clinical data or ever seen any clinical data on those two

products?
A Not specifically, no.
Q Can you identify any transvaginal mesh product that has more published clinical data than Prolift®?
A I think the relevant point is that there was no data on Prolift® at launch.
MS. JONES: Move to strike as nonresponsive.
BY MS. JONES:
Q My question, Doctor, was: Can you identify any transvaginal mesh product for whom there is more published clinical data than on Prolift®?
A This is 2012. It's an entirely different situation. And Ethicon pulled Prolift® off the market in the face of all this data because it was not safe and not effective.
MS. JONES: Move to strike as nonresponsive.
BY MS. JONES:
Q My question for the third time, Doctor, is: Can you identify a single transvaginal mesh product for which there is more published clinical data than Prolift®?

A No.
Q Can you identify other than Prolift® any transvaginal mesh product for whom there is more published data than Gynemesh® PS?
A No.
Q Have you reviewed, Doctor, any of the preclinical bench or animal studies done on the Prolene® PS or the Prolene® mesh?
A The Gynemesh® PS mesh?
Q Or the Gynemesh® PS mesh.
A Yes.
Q What studies have you reviewed?
A The animal studies in a rat model looking at mesh implantation in an abdominal location for short-term histologic changes.
Q I think I asked you this yesterday. But I'm not certain. Have you yourself actually ever performed any animal studies?
A I have assisted the fellows in their work with Dr. Moalli at the University of Pittsburgh in her studies of -- in her animal studies. And at the Cleveland Clinic I supervised the fellows in the performance of their research with animals.
Q Have you ever actually implanted mesh in an animal?

A No.
Q Have you ever actually taken mesh out of an animal and examined it pathologically?
A I have not taken mesh out of an animal. I have examined it pathologically.
Q The tissues from the animal?
A Yes.
Q Have you ever published on any of those animal review studies?
A They have been published. I am not a co-author.
Q Doctor, have you ever performed any studies to evaluate the foreign body response to any mesh?
A No.
Q What is your understanding of the size of a microphage?
A I'm sorry?
Q Do you know what the size of a microphage is?
MR. SLATER: A macrophage?
THE WITNESS: Macrophage? Macrophage is what you're saying?
BY MS. JONES:
Q Yes, yes.

A Macrophage is in the range of 10 to 20 microns.
Q Do you know what the size of a leukocyte is?
A Macrophages are in the family of leukocytes, so, yes, 10 to 20 microns.
Q Have you ever seen any criticism by the FDA of the pore size of the Gynemesh® PS or the porosity of the Gynemesh PS?
MR. SLATER: Can I have that question read back? I might have missed something there.
(The court reporter read the record as follows:
"QUESTION: Have you ever seen any criticism by the FDA of the pore size of the Gynemesh® PS or the porosity of the Gynemesh PS?")
MR. SLATER: Objection; assumes the issue was even ever looked at by the FDA.
You can answer.
THE WITNESS: Not to my knowledge.
BY MS. JONES:
Q Have you used polypropylene sutures in your surgeries?
A Yes.
Q Since the time you were in your residency?

A Yes.
Q Ever had any difficulties with use of those sutures?
A Difficulties like what?
Q I'm asking you, Doctor.
MR. SLATER: She's asking you to define what you mean by "difficulties." It's a pretty ambiguous term, which I object to.
BY MS. JONES:
Q You can't answer that question, Doctor?
MR. SLATER: Can you refine what you mean by "difficulties"?
MS. JONES: I'm asking the doctor whether she can answer the question.
MR. SLATER: She already asked you to define the term so I don't understand why you won't do it.
MS. JONES: Because I'm asking the questions, counsel.
MR. SLATER: Okay. But she's already asked you to refine what you mean. So normally when you're taking a deposition and the witness says I don't know what you mean, you refine the question.
MS. JONES: This is the first deposition I've ever taken, Doctor -- I mean,

counsel.
MR. SLATER: If you're going to start calling me Dr. Slater, okay, you're not going to be the first one. It's a big step up for me. Wow.
BY MS. JONES:
Q Have you ever filed an adverse experience report with respect to polypropylene sutures?
A No.
Q Have you ever reported anywhere any degradation with polypropylene sutures?
A No.
Q Have you ever seen any evidence of degradation in your surgeries?
A No.
Q In terms of the mesh that you used in abdominal sacrocolpopexy, have you ever seen evidence of degradation there?
A I wouldn't see evidence of degradation because it's -- if it's going on, it's going on in the patient's body.
Q Have you ever seen any removed mesh, Doctor, that shows any evidence of degradation?
A Yes.
Q When did you see that?
A In my review of the medical literature.

Q My question, Doctor, was whether or not you had actually seen mesh that showed any evidence of degradation.
A I believe I answered your question.
Q You've held mesh that shows evidence of degradation?
A You didn't ask me if I held it.
Q Let's see if we can get on the same wavelength.
MR. SLATER: Whatever you do, don't get on the same wavelength.
BY MS. JONES:
Q I'm asking you, Doctor, whether or not you have held in your hands any polypropylene mesh of which you decided or could discern any evidence of degradation.
A No.
Q Have you ever had a patient who had a failure of mesh that you attributed to degradation?
A I can't say -- I can't say. I can't say no for sure. Patients experience failure and it's possible that it's due to suture breakage, which would be due to suture degradation.
Q All right. Maybe we miscommunicated. I was asking you about the mesh itself this time.

MR. SLATER: What's the question? She must have misunderstood.
MS. JONES: I asked her whether or not she had ever had a failure of mesh in a patient that she attributed to degradation.
THE WITNESS: No.
BY MS. JONES:
Q Prior to becoming or being retained as an expert in this litigation, is it fair to say that you had not previously reviewed the literature on polypropylene?
A In my experience as the program director for the pelvic floor disorders network, we were considering the design of a trial using mesh. At that time I would have reviewed the literature to understand what had been done with mesh products and what other research was needed.
Q What can you remember about your review of the literature at that time specifically as it relates to polypropylene mesh?
A The literature was lacking.
Q What can you remember about your review of the literature at that time with respect to polypropylene mesh?
A There may have been case series and

retrospective chart reviews. I don't recall seeing any prospective research.
Q Do you recall reviewing any biomaterials literature at that time with respect to the characteristics of polypropylene?
A I may have. I can't say for sure.
Q Do you remember reviewing any literature with respect to the historical use of polypropylene in the body?
A I would expect so.
Q Well, can you tell me as you sit here today when polypropylene was first used in the body?
A I believe it was in the '50s or '60s.
Q Do you know when polypropylene mesh was first used in the body?
A I believe in that same time, '50s or '60s.
Q As you sit here today, Doctor, can you identify any alternative mesh product that you believe is a better product for use to treat prolapse than Gynemesh® PS?
A I don't believe mesh of any type in the polypropylene family is an appropriate choice for transvaginal mesh implantation.
Q Let me ask the question a little bit differently. Can you identify for me any type of

mesh that you believe is appropriate for use transvaginally?
A Based on my background and my study, my conclusion is that any mesh placed transvaginally for prolapse exceeds -- the risks far exceed the benefit.
Q Am I correct then, Doctor, that you, as you sit here today, cannot identify for us an alternative mesh to Prolift® for use transvaginally to repair prolapse?
A You're suggesting an alternative is necessary. I don't agree with that.
Q I'm just asking you, Doctor, whether or not you can identify one.
MR. SLATER: Well, let me just ask what the question means. She just told you she doesn't think any of the meshes should be used. So when you say can you identify one, are you asking her to just list them?
MS. JONES: Could we not have speaking objections?
MR. SLATER: Well, I object to the form. It's incredibly ambiguous, the question. Could you rephrase it?
MS. JONES: How about let me conduct

this and you just say objection, as I have done at your depositions, and we'll be in good shape.
MR. SLATER: Well, you went a little past the word "objection," with all due respect, so I think the question is extremely confusing and ambiguous.
BY MS. JONES:
Q I'm asking you, Doctor, this question: You have told us that you do not consider any mesh to be appropriately used for the transvaginal treatment of prolapse; is that correct?
A I believe I said polypropylene mesh or mesh in the polypropylene family.
Q All right. That's what I thought you said. So can you tell me then of any mesh that can be appropriately used transvaginally?
A I don't believe such a product exists.
Q So it's fair to say that while you're saying polypropylene mesh should not be used, that you're not suggesting that there is a better alternative mesh than polypropylene?
A I don't agree with your use of the word "alternative."
Q Well, I'm trying to understand your opinions, Doctor. So what I'm asking you is, is

there a better mesh of which you are aware than the polypropylene mesh?
A A yes or no answer would not -- would be misleading. You're suggesting that there's a comparison to be made. I can use the words of one of Ethicon's own employees: The best of a bad lot, talking about polypropylene.
MS. JONES: Move to strike as nonresponsive.
BY MS. JONES:
Q My question, Doctor, doesn't relate to polypropylene. My question relates to whether or not you have an opinion that there is a mesh that has better characteristics for implantation in the body than polypropylene.
A I have answered that I don't believe a mesh exists that's appropriate for transvaginal implantation for Prolift® -- prolapse. Excuse me.
Q So it would be your opinion that no mesh should be on the market for the transvaginal treatment of prolapse?
A I believe that the mesh -- let me start again. The greater part of my knowledge revolves around Gynemesh® PS mesh used in Prolift®. To my understanding, every product on the market went

through the 510(k) process, which in my opinion is inadequate to demonstrate the safety of these meshes.
MS. JONES: Move to strike as nonresponsive.
BY MS. JONES:
Q My question, Doctor, was this: Is it your testimony and your opinion that no mesh should be on the market for the transvaginal treatment of prolapse?
A My opinion is that if a mesh belongs on the market for the transvaginal treatment of prolapse, the safety needs to be established first.
MS. JONES: Move to strike as nonresponsive.
BY MS. JONES:
Q As we sit here today, Doctor, is it your opinion that no mesh used for transvaginal treatment of prolapse should be on the market?
A I believe I answered that question. To my understanding, all of the products currently on the market have gone through 510(k) process, which in my opinion is insufficient to establish their safety. If they're not safe, they don't belong on the market.

Q So your opinion is that no mesh currently used for the transvaginal treatment of prolapse should be on the market?
A I believe I answered that question.
Q I'm just asking you, Doctor, am I correct that that is your opinion?
A I don't believe that -- I believe I've answered that question and I don't believe that question can be answered with a simple yes or no.
Q Well, tell me then, Doctor, identify for me as you sit here today the mesh that you believe should be on the market for the transvaginal treatment of prolapse.
A I already told you I don't believe that mesh exists at this point in time.
Q Do you know how many doctors in this country have used polypropylene mesh for the transvaginal treatment of prolapse?
A No.
Q You do know that a significant number of surgeons in this country have used transvaginal mesh for the treatment of prolapse; correct?
A I know that a significant number of surgeons have used mesh and have abandoned it because they believe it's too unsafe to be used in

their patients.
Q You know that not every woman who has had transvaginal mesh used to correct prolapse has experienced complications, don't you?
A Not yet. These women are at lifelong risk for complications from the permanent implantation of Prolift® mesh.
Q Based upon the studies and the literature that are out there, 75 to 80 percent of the women who have transvaginal mesh used to correct prolapse have had no major complications; correct?
A Not yet. There is no safe time -- one of your experts in the medical literature -- there is no safe time after mesh implantation for eliminating the risk of complications.
MS. JONES: Move to strike as nonresponsive.
BY MS. JONES:
Q As we sit here today, today, Doctor, 75 to 80 percent of the women who have had transvaginal mesh correction of Prolift® have experienced no significant, major complications; correct?
MR. SLATER: Objection.
THE WITNESS: Where do you get the --
MR. SLATER: You can go ahead.

THE WITNESS: Where do you get the 75 to 80 percent?
BY MS. JONES:
Q Well, let me just ask you first, do you agree with that? That's my question.
A I would like to know the basis for your question. I would like to know the basis for which you claim that 75 to 80 percent of women after Prolift® implantation have not had significant, major complications.
Q You know, Doctor, I get to ask the questions here.
A And I get to have the questions clarified.
Q Well, my question to you is do you agree with that figure or not?
A I am not going to agree with that statement on the basis of a lack of clarification.
Q Have you looked at the medical literature with respect to the use of transvaginal mesh?
A Short term.
Q My question, Doctor, is have you looked at the medical literature with respect to the use of transvaginal mesh?
A Yes.
Q And that medical literature reports on

complications noted in the studies, whether it's case studies or randomized trials, does it not?
A It may. It may not be complete or accurate. For example, in the TVM studies that were published, the five-year study that was published in the medical literature is inaccurate and does not accurately provide the extent of complications experienced by women who had the TVM procedure.
Q As I recall, Doctor, you have never examined a woman that's had Prolift®; is that correct?
A That is correct.
Q Have you ever spoken with a woman that's had Prolift®?
A It's not on her forehead.
Q I'm sorry?
A It's not on her forehead. Not to my knowledge.
Q Have you ever done --
MR. SLATER: Do you want to take a break?
THE WITNESS: Is this a good time for a break?
MR. SLATER: If you need a break, it's a good time.

BY MS. JONES:
Q Let me ask this question first. Have you ever done any separate analysis, Doctor, of any literature regarding Prolift® complications?
MR. SLATER: What do you mean by a "separate analysis"? Beyond what she's done in this case?
THE WITNESS: What do you mean by "separate analysis"?
BY MS. JONES:
Q Have you ever sat down, Doctor, and done a meta-analysis of studies involving Prolift®?
A No.
MS. JONES: Let's take a break.
(Short recess.)
BY MS. JONES:
Q Doctor, in your reports that outline your opinions in this case, have you set forth your criticisms of the medical literature and the individual studies?
A Yes.
Q To the best of your knowledge as you sit here today, have you identified all of those criticisms?
A Yes.

Q If we turn to the instructions for use for Prolift®, you have opinions about the adequacy of the warnings that were included within them; am I correct?
A Yes.
Q Can you tell me, Doctor, or just summarize for me, if you would, your opinions of what should have been in the IFU in terms of complications that were not in there and when they should have been included?
MR. SLATER: Do you mind if she has her report available or the IFU available? Because she has nothing in front of her right now.
MS. JONES: I understand. And I will stipulate to you that whatever is in the report is in the report. I'm not trying to trick you. I'm just trying to move quickly through this.
MR. SLATER: Because it's kind of hard to remember everything sitting here.
THE WITNESS: I would prefer to have my report.
MS. JONES: Then you're more than welcome.
MR. SLATER: Unless counsel might want you to just throw out a couple and she's just

going to ask you questions about the few that you come up with now as long as we understand --
MS. JONES: If you want to have your report, you can have it. I was, frankly, just trying to move along quickly in the hopes we could finish today. I'm not trying to put anybody at a disadvantage.
MR. SLATER: I'm fine with doing this. I just don't want it to be construed later that her testimony was some complete list. That's all. As long as we have that understanding, it's fine. It's up to you.
MS. JONES: I'm willing to say that whatever's in the report is in the report. I'm not trying to trick you in any way, shape, or form. But I'm also willing to let you have the report and go through it.
THE WITNESS: Could you repeat the question, please?
(The court reporter read the record as follows:
"QUESTION: Can you tell me, Doctor, or just summarize for me, if you would, your opinions of what should have been in the IFU in terms of complications that were not in there and

when they should have been included?")
THE WITNESS: Well, I can answer the last part of the question first. Clearly they should have been included from the moment Prolift® was on the market.
BY MS. JONES:
Q While you're looking for that, Doctor, is it your testimony that you believe that every potential complication associated with the use of Prolift® was known at the time that it was first marketed?
A I understand that was the testimony of Ethicon employees; yes.
Q I was asking really for your opinion at the time.
A No. My opinion at the time was that all of the risks were not known and that evolved over time. In fact --
Q How do you understand that those risks --
A -- the treating physicians of the plaintiffs testified that they learned over time several of the contraindications and additional risks that Ethicon failed to inform them of.
Q What is your understanding of how that evolved over time?

A My understanding is that patients with preexisting chronic pain conditions are contraindicated to undergo the Prolift® procedure because they are at such higher risk of developing either an exacerbation of their preexisting condition or the development of a new pain condition and that was not warned of at the time of Prolift® launch.
Q Let me ask you this, Doctor: In terms of women with a chronic pain condition, those women would be at increased risk of pelvic pain regardless of the type of surgery that was performed, would they not?
A That is not my clinical experience.
Q In the course of your clinical experience, did you perform prolapse surgery on patients with a chronic pain syndrome?
A Yes.
Q Tell me what types of chronic pain syndrome you would perform surgery on.
A Fibromyalgia, arthritis, migraine headaches. That's all I can think of at the moment.
Q Do you have any idea as you sit here today how many women you performed prolapse surgery on who had fibromyalgia?

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A I do not know.
Q How about how many women had migraine headaches?
A I do not know.
Q Did you take any special precautions for women who had chronic pain syndrome?
A I counseled them that in the immediate postoperative period they may experience more pain and we will do everything we can to manage that effectively for them. Outside of the immediate four to six weeks after surgery, that should have resolved to baseline.
Q Did you counsel all women whom you knew had had chronic pain conditions about that?
A That would have been my practice.
Q Is that something that you think would be a standard practice for surgeons performing prolapse surgery?
A I don't want to speak for all surgeons performing prolapse surgery.
Q Is that something that you trained your residents to do?
A Yes.
Q Is that something that you trained your fellows to do?

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A Yes.
Q Is that something that you did beginning in the course of your residency?
A I don't remember that specifically.
Q When did you begin to counsel patients about chronic pain syndromes?
A That would have been in my residency when they were surgical candidates.
Q So from the time you were in your residency, you would have counseled patients on those chronic pain situations?
A Correct.
Q And that was something that you were trained to do in your residency?
A Correct.
Q And what do you consider to be chronic pain conditions or syndromes?
A I don't understand your question. Are you asking again for a list of chronic pain conditions?
Q I am.
A All chronic pain conditions?
Q What I'm asking for is a list, Doctor, of the conditions that would prompt you to counsel patients about that.
A So you're asking for a list of all chronic

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pain conditions?
Q I am, if that's what you would --
A Okay. To the best of my recollection at the moment, I already mentioned fibromyalgia, arthritis -- I can't remember the third thing I said.
Q You said migraines.
A Migraines. Thank you. Interstitial cystitis, endometriosis. Many chronic pain syndromes don't have a diagnosis. They are described as a chronic pain syndrome. I'm trying to give you a list of the conditions that actually have a diagnosis.
Q Well, can you give me some -- other than what you've already given, are there other examples of complaints that women had experienced that would prompt you to have the conversation with them about chronic pain and any increased risk?
A Pelvic muscle spasm. I can't think of any other conditions at this time.
Q If you became aware as a physician that a patient had complained of significant pain following earlier surgical procedures, would you have counseled them on that?
MR. SLATER: Objection; ambiguous.

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You can answer.
THE WITNESS: Significant pain that became chronic?
BY MS. JONES:
Q That's what I'm trying to ask you. I'm trying to understand under what circumstances you would counsel patients on chronic pain and any increased risk.
MR. SLATER: Objection; ambiguous.
You can answer.
THE WITNESS: I don't know that I can add to the list I've already given you.
BY MS. JONES:
Q But you would counsel patients about that regardless of the type of prolapse surgery that you were going to perform?
MR. SLATER: Objection.
You can answer.
THE WITNESS: Yes, yes.
BY MS. JONES:
Q I mean, it didn't make any difference whether it was a vaginal sacrospinal ligament fixation or an abdominal sacrocolpopexy?
A Correct.
Q Other than the chronic pain syndrome that

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you just mentioned, are there other complications that you believe should have been included within the IFU at the time of launch?
A Infection potentiation was included as a risk and that is an inadequate statement to --
Q I'm sorry. What --
A Oh, Page 405. And that is an inadequate description of the nature and extent and severity of the kinds of infectious complications that can occur after the Prolift® procedure and permanent Prolift® mesh implantation.
Q Can you identify for me, Doctor, any studies that show a statistical significant increased risk of infection associated with Prolift®?
A There are two types of infections. The first type of infection is an acute infection, an abscess, as an example. And to my knowledge, that type of infection has not been increased after Prolift® procedures.
The second type of infection is a chronic low-grade infection, and that is something that occurs more commonly after Prolift® surgery than after native tissue repair.
Q And can you tell me what study you're

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relying upon when you say that?
A Because Ethicon failed to study the etiology of mesh erosion, the etiology is not completely understood. Surgeons believe that a chronic low-grade infection is responsible for mesh erosion and recurrent mesh erosion. And in that way that is an example of a chronic low-grade infection that can only occur after mesh implantation and specifically Prolift®.
Q Doctor, my question was really can you identify specifically for me what you're relying upon when you make those statements?
A All of the articles that demonstrate at least a 10 percent -- not at least -- an average of 10 percent and many studies showing much higher rates of mesh erosion.
Q Erosion, not infection, erosion?
A Again, because the etiology is not understood because Ethicon failed to study this, mesh -- surgeons are still trying to figure out what causes mesh erosion. And it's plausible from a biological standpoint that these are low-grade subclinical infections and are causing mesh erosion and recurrent mesh erosion.
Q And that is a hypothesis at this point?

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A I don't think I would label it a hypothesis.
Q Then can you identify for me a study that shows a statistically significant increased risk of a low-grade infection?
A Mesh erosion.
Q I'm asking you for a study. Can you just identify for me what it is that you're relying upon when you make those comments?
MR. SLATER: With all due respect, I'm not going to go through what she said -- and you're tilting your head at me -- but, you know, she's given you a very, very specific answer and given you chapter and verse on a whole extent of literature.
MS. JONES: Counsel, I've asked four times --
MR. SLATER: And you've gotten a direct answer.
MS. JONES: I have asked four times for the identification of a study and we don't have a study that's been identified yet. If there's not one, there's not one.
BY MS. JONES:
Q I'm just asking what it is specifically

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that you rely upon. What is it that you rely upon for those statements?
A The Altman study didn't even report the number of patients who experienced mesh erosion. It reported the number of patients who required surgery for mesh erosion. Every single study of Prolift® in the literature identifies that specific rate of mesh erosion in that study. That's the studies -- those are the studies I am relying on.
Q So you're relying on erosion as being identical to infection?
A To the best of my understanding in 2012, because Ethicon failed to study this and understand the etiology of mesh erosion before they put the Prolift® or even the Gynemesh® PS mesh on the market, etiology of mesh erosion is not completely understood. To my understanding, the most logical explanation is a subclinical low-grade infection because the mesh is contaminated on placement and that contamination cannot be cleared. It shows itself as mesh erosion and recurrent mesh erosion.
MS. JONES: Move to strike as nonresponsive.
BY MS. JONES:
Q Doctor, tell me, if you would, what you

rely upon in support of your opinion that a subclinical infection causes mesh erosion.
MR. SLATER: In addition to what she just told you, counsel?
MS. JONES: I'm just asking her to tell me.
MR. SLATER: Hang on. It's asked and answered. So I'm asking you do you want her to repeat what she said or in addition to what she said?
MS. JONES: I want her to tell me what she relies upon specifically --
MR. SLATER: She just told you.
MS. JONES: -- for the opinion that a subclinical infection causes erosion.
MR. SLATER: And you were asking in the literature. Now it goes beyond the literature? She can bring out anything else?
MS. JONES: I've never gotten anything out of the literature.
MR. SLATER: Well, you have. She listed every single Prolift® study with erosion rates.
MS. JONES: Counsel, come on. It's inappropriate.

MR. SLATER: It's not inappropriate. She said it three times.
MS. JONES: It is inappropriate. And I don't want to go to the judge, but even the judge is going to recognize these are speaking objections. We've got an expert witness here who can answer the questions. This is inappropriate.
MR. SLATER: Well, it's inappropriate, too, for counsel to pretend that an answer hasn't been given and to continue to ask the same question because you don't like the answer.
MS. JONES: No, I haven't gotten the answer. And we can look at it and we can ask Judge Higbee to look at it.
MR. SLATER: You have the right to do that. I feel very confident that what I'm doing is appropriate right now.
MS. JONES: Well, I don't think it's appropriate, what Judge Higbee thinks is appropriate. So I'm going to ask the question one more time.
BY MS. JONES:
Q I'd like, Doctor, for an answer to the question. Specifically what is it upon which you rely that says a subclinical infection causes

erosion?
A In addition --
MR. SLATER: Same objection.
You can answer again.
THE WITNESS: In addition to all the evidence in the medical literature, I rely on the experience and opinion of surgeons who are experienced in caring for women who have mesh erosion and recurrent mesh erosion and who have studied this over their years of clinical practice in order to somehow find a better way to treat these women, because we don't --
BY MS. JONES:
Q Can you name those surgeons for me?
A Dr. Shlomo Raz.
Q Anybody else?
A I don't remember his name. He is the infectious disease expert from the University of Connecticut.
Q Okay. The infectious disease expert in this litigation?
A Yes.
Q Anybody else?
A That's all I can think of off the top of my head.

Q Do you believe, Doctor, and is it your opinion that the erosions associated with transvaginal mesh are different from the erosions with other mesh?
MR. SLATER: Objection to the form.
You can answer.
Highly ambiguous.
You can answer.
THE WITNESS: Yes.
BY MS. JONES:
Q How?
A The mesh is implanted through what is termed surgically a clean contaminated environment. It's laden with bacteria from the moment it's in the woman's body.
Q That's with the transvaginal mesh?
A Correct.
Q What causes erosion in the mesh used in abdominal sacrocolpopexy?
A The characteristics of the mesh incite an inflammatory reaction and foreign body reaction that disturbs the surrounding tissue and results in the formation of an erosion.
Q And that's different from what happens with a transvaginal mesh?

A Are you asking me to differentiate abdominal sacrocolpopexy?
Q I'm asking you how the erosions that occur with meshes not used in transvaginal surgery are caused and how those differ from what's used in transvaginal surgery.
MR. SLATER: Objection to the form. You can answer.
THE WITNESS: First of all, in abdominal sacrocolpopexy the mesh is placed on the outside of the vagina from an internal basis. In transvaginal mesh implantation, the vagina is incised, dissected, creating whatever level of tissue damage occurs with incisions and dissection. And, as I said, the mesh is contaminated in placement because of the natural vaginal microenvironment that cannot be sterilized at the time of surgery. The surgical field cannot be separated, draped in such a way as to isolate a specific area that you're operating on in order to prevent the introduction of bacteria with mesh implantation. That's one reason.
BY MS. JONES:
Q I'm sorry, Doctor. We're just not communicating. If you have mesh that's used in

abdominal sacrocolpopexy, there have been reports of erosion; correct?
A Vaginal erosions, correct.
Q And my question to you is whether or not the cause of those erosions is different from the cause of the erosions you see with transvaginal mesh.
A As I've already said, the etiology of erosions is not fully understood. Mesh -- bacterial contamination of the mesh is logical in understanding why mesh erosion occurs and why mesh erosion occurs so much more frequently in transvaginal Prolift® mesh implantation than in abdominal mesh implantation.
Q And so is the answer that as you sit here today, you don't know whether or not there's a different etiology for mesh erosion associated with abdominal sacrocolpopexy versus the transvaginal inserted mesh?
A That is correct. The etiology of mesh erosion is not completely understood.
Q We started this discussion when we were talking about your criticisms of the IFU. And I guess my question, Doctor, is if we go through this, are you going to take me through each one of these

things that you've noted and say you have completely set out your opinions here in your report?
A My opinions are completely set out in my report.
MR. SLATER: Obviously, counsel, there are supplemental reports, too.
BY MS. JONES:
Q Doctor, have you ever talked with or visited with a surgeon who has used Prolift® to treat women?
A You mean specific to the Prolift®?
Q Yes, ma'am.
A No.
Q Have you ever spoken with a doctor who has gone through the Prolift® professional education program about that program?
A No.
Q Have you ever spoken with a doctor who has gone through either a proctorship or a preceptorship with respect to Prolift®?
A No.
Q Have you ever attended any professional meetings where studies with respect to Prolift® were specifically discussed?
A Yes.

Q What were those?
A I don't remember specifically. It would be in the years between 2005 and 2007, the end of 2007, when I was still attending professional meetings.
Q Do you remember who presented?
A No.
Q Do you remember what study was presented?
A No.
Q Do you remember anything about any discussion at the time?
A Discussion, very controversial. Doctors were very gravely concerned that the widespread use of mesh was happening without evidence of safety and, in fact, with strong evidence of grave harm to patients without demonstrated benefit.
Q Can you identify for me, Doctor, any doctors who expressed that view?
A Dr. Ingrid Nygaard; Dr. Peggy Norton; Dr. Linda Brubaker; Dr. Mary Pat FitzGerald; Dr. Matt Barber; Dr. Scott Smilen, S-M-I-L-E-N; Dr. Robert Porges, P-O-R-G-E-S; Dr. Bob Shull, S-H-U-L-L. Do you want me to keep going?
Q All of these doctors expressed a view at this meeting that you attended?

A I'm reflecting on a number of meetings.
Q How many meetings did you attend where Prolift® was discussed?
A I can estimate four to six.
Q And can you tell me what meetings they were?
A I can tell you what meetings they were likely to be. The American Urogynecologic Society and the Society of Gynecologic Surgeons.
Q And you would have attended four to six of those between 2005 and 2007?
A They're held annually so that would be six, yes. They're separate meetings. Three years, two meetings a year, six meetings.
Q I asked you to identify for me the people that expressed concerns. There were also people expressing the other side of that, were there not?
A Yes. Those doctors were largely paid by Ethicon.
Q There were doctors who were not paid by Ethicon that were involved in and used mesh, did they not?
A Yes.
Q Do you remember any of the presentations where doctors suggested that the use of transvaginal

mesh was appropriately used for prolapse?
A No, I do not remember specific presentations.
Q Do you remember the names of any doctors who presented on that?
A Not specifically.
Q Do you remember whether or not you ever saw any presentation involving any of the members of the TVM group?
A I don't remember specifically.
Q Do you know how many academic institutions were training surgeons on the use of transvaginal mesh?
A No.
Q Do you know how many fellowship programs trained fellows on the use of transvaginal mesh?
A No.
Q Do you know how many fellowship programs continue to train fellows or surgeons on the use of transvaginal mesh for treatment of prolapse?
A Well, they can't train on Prolift® because it's been pulled off the market and --
MS. JONES: Move to strike as nonresponsive.
THE WITNESS: -- Gynemesh® PS mesh

has been restricted to abdominal use.
MS. JONES: Move to strike as nonresponsive.
BY MS. JONES:
Q Doctor, my question was: Do you know how many fellowship programs continue to train fellows on the use of transvaginal mesh to treat prolapse?
A No, I don't.
Excuse me. I'd like to take two minutes to go to the restroom.
MS. JONES: Please.
(Short recess.)
BY MS. JONES:
Q Doctor, I'm going to talk about Ms. Gross for a second. So until and unless I tell you something else, that's who we're going to be talking about. Okay?
A Okay.
Q As I understand the opinions that have been set forth in your report, you believe that she experienced left pudendal neuralgia from Prolift®; am I correct?
A Correct.
Q Partial urinary retention?
A Correct.

Q Mesh erosion and exposure?
A Correct.
Q Fear, anxiety, and depression?
A Correct.
Q And that she is fully disabled?
A Correct.
Q Now, did I correctly summarize the case-specific opinions that you have with respect to Ms. Gross and her injuries?
A Yes.
Q I know that you testified yesterday that you were initially contacted in this litigation in the fall of 2009. When were you first asked to review the medical records of Ms. Gross?
A I don't know specifically.
Q Can you give me an approximation of when you first began to review Ms. Gross' medical records?
A No.
Q Can you tell me how long you spent reviewing Ms. Gross' medical records in preparation of that report?
A No, I can't estimate that.
MS. JONES: Counsel, I think you told me yesterday that you would get a copy of the

financial disclosure.
MR. SLATER: Oh, yeah. It's sitting around the corner. Want me to look for it now?
MS. JONES: Well, no, but let's get it at the break.
MR. SLATER: Absolutely.
MS. JONES: Because I would like to see it before and mark that.
MR. SLATER: I have the packet with all the experts so I'll give you the whole thing, because apparently no one showed it to you.
MS. JONES: I'm not suggesting --
MR. SLATER: They're so busy passing notes to you they're not giving you our disclosures.
BY MS. JONES:
Q Is there any way, Doctor, that you can separate out for us the time that you spent reviewing and preparing your opinions with respect to Ms. Gross?
A No.
Q Would the answer be the same with respect to Ms. Wicker?
A Yes.
Q And I think it's implicit in what I just asked you, but it is also correct then that you did

not separately invoice Mr. Slater for the preparation of your opinions with respect to Ms. Gross?
A Correct.
Q Or Ms. Wicker?
A Correct.
Q To the best of your knowledge, have you reviewed the complete medical records of Ms. Gross?
A Complete as in her whole life?
Q Well, have you reviewed the complete medical records of every doctor whose records you have reviewed?
A Yes, all material provided to me I have reviewed.
Q But that's not really my question. My question is: Did you receive excerpts from my doctors' files?
A No. Well --
Q Here's the question: Sometimes doctors only receive copies of the operative reports, for example, and not the notes. And that's all I'm asking is whether or not you reviewed the complete records of the doctors that you have identified in the supplemental materials reviewed or whether you only received certain portions of those files.

A If I understand your question correctly, you're asking me to identify something that I don't know I've seen. So I don't know how to answer that.
Q I'm asking the question because, frankly, Doctor, what I looked at earlier in terms of the materials reviewed didn't necessarily have all the Bates numbers and all there so I can't tell exactly what you've reviewed from each doctor's files. But I do know that you can sometimes review the files and it's apparent that you don't have the complete file from a given doctor. And that's what I'm asking you.
A I -- it was not obvious to me that chunks were missing. I can't say for certainty otherwise.
Q That's all I'm asking. I'm just asking whether or not, to the best of your knowledge, you received the complete file from each of the doctors whose records you reviewed.
A Well, again, complete. For example, Dr. Likness cared for Mrs. Gross, I don't know, what beginning -- beginning at what age, but he was her lifetime family physician. So have I reviewed every page of her medical records related to Dr. Likness? Probably not.
Q Were you furnished with any summary of the

medical records?
A Yes.
Q Were you furnished with a summary of the medical records for both Ms. Wicker and Ms. Gross?
A Yes.
Q Do you know who prepared that summary?
A I don't remember.
MS. JONES: I know we're going to have an argument about this, but I'm going to request those summaries.
MR. SLATER: You can send me a letter. I mean, my position is that they were provided only to give an idea of what was being provided, that Dr. Weber relied on the records, not on the summary, so it's work product.
MS. JONES: Well, I know that's your position. We'll take it up later. But I'm going to ask for those. And I would ask you --
MR. SLATER: Are you going to send me all your summaries? Are you going to send me all the summaries that you did for your experts?
MS. JONES: I don't send summaries to my experts.
MR. SLATER: Someone does.
MS. JONES: Not that I know of.

BY MS. JONES:
Q Do you know whether or not you received those summaries -- were they in electronic form or hard copy?
A Electronic.
Q I'm going to ask you, just as I did yesterday, if you would maintain those permanently up until the time of trial and so forth so that when the Court decides what's appropriate for us to get or not we will have access to them. Okay?
A Yes.
Q Do you know any of the treating physicians for Ms. Gross?
A No.
Q Are you familiar with Dr. Antolak?
A Antolak?
Q Uh-huh.
A I don't know how to say his name either. I'm familiar with him now, of course.
Q When you say you're familiar with him now, in what sense are you familiar with him now?
A In the course of being a treating physician for Mrs. Gross.
Q Have you reviewed his deposition?
A Honestly, I need my list of materials

reviewed to know for sure.
Q I will represent to you I did not see it listed on your materials reviewed so I'm --
MR. SLATER: Wait. You're looking at the wrong list then.
MS. JONES: Well, I may be.
MR. SLATER: There's been updated lists. I'm just telling you. He's definitely listed. I'll find out during lunch.
MS. JONES: I mean, let's do this during lunch: Can we get what you believe is the complete list --
MR. SLATER: Absolutely.
MS. JONES: -- of everything at lunch?
MR. SLATER: Yes.
MS. JONES: Just check, because I will represent to you that what I was looking at did not have that deposition transcript listed.
BY MS. JONES:
Q Did you receive the entire deposition transcripts for the doctors and witnesses that you reviewed?
A Do you mean when I received deposition transcripts, were they complete?

Q Yes.
A Yes.
Q Did you review summaries of the depositions?
A In some cases, yes.
Q Were you furnished summaries of all of the depositions?
A No.
Q Can you tell me what summaries you reviewed of the depositions?
A Dr. Benson. That's the only one I can remember.
Q I asked you, Doctor, when you had reviewed the information that relates to Ms. Gross. You said you couldn't remember. Did you actually look at it during this year, 2012?
A Yes.
Q Had you looked at any portion of those records before?
A Yes.
Q Do you remember whether or not you looked at them before the fall of 2011?
A I don't remember.
Q Did you receive summaries of any of the depositions of the Ethicon witnesses?

A Yes.
Q Tell me which witnesses you received summaries on.
A To the best of my recollection, Dr. Piet Hinoul. That's all I can remember.
Q Did you receive complete deposition transcripts on the Ethicon witnesses?
A Yes.
Q Did you receive all of the exhibits to those depositions?
A No.
Q Have you requested any other Ethicon documents for review that you've not yet seen?
A No.
Q Before you reviewed the deposition of Dr. Antolak, were you familiar with his reputation as a specialist on pudendal neuralgia?
A No. Well, let me just say in reviewing the records of Mrs. Gross, she had seen Dr. Antolak. So at that point I became aware of his specialty in pudendal neuralgia. So that would be at some time before his deposition.
Q Did you do any investigation or research on Dr. Antolak?
A I believe I searched his name on PubMed,

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the medical literature.
Q And did you do any searches on any of Ms. Gross' other doctors?
A Yes; Dr. Hibner, again from the medical literature.
Q And did you pull and review any of the medical articles written by either Dr. Hibner or Dr. Antolak?
A Yes.
Q And are the articles that you pulled and reviewed identified on the list of materials reviewed?
A Yes, if there were articles.
Q Let me ask you this: Do you recall reading articles authored by either of those two doctors?
A I can't be sure. If I read them, they're on the list.
Q Let me ask you, have you reviewed any materials from the Social Security Administration on Ms. Gross?
A No.
Q You identified three experts' reports that you had reviewed before preparing your opinions, and those were those of Dr. Serrato, Dr. Welch, and

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Dr. Provder; is that correct?
A Mr. Provder, yes.
Q And did you rely upon the report of Dr. Serrato in formulating your opinions?
A Yes.
Q Did you review the ultrasounds that Dr. Serrato performed?
A No.
Q Have you ever seen any ultrasounds on Ms. Gross?
A No.
Q Have you seen any radiology at all with respect to Ms. Gross?
A No.
Q Have you seen any pathology with respect to Ms. Gross?
A Yes.
Q Tell me what you've seen.
A I have seen histology slides, photomicrographs of mesh and tissue.
Q Have you seen the actual slides or just the photomicrographs?
A Just the photomicrographs.
Q And do you know who prepared those photomicrographs?

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A I cannot say for sure.
Q Are the photomicrographs specifically identified on the list of materials reviewed according to which institution they would have come from?
A No.
Q Are they identified in any way?
A I believe they're identified by her name, Linda Gross, and by a number.
Q And what do you think that number refers to?
A I don't know.
Q You don't know whether they're exhibits to the deposition or whether they're something from the medical records?
A They may have been used as exhibits. They are not labeled as exhibits.
MS. JONES: Counsel, I'm going to ask specifically that those photomicrographs be produced.
MR. SLATER: You have them already.
MS. JONES: I just want to know which ones they are so that we --
MR. SLATER: You have them all. She was given everything I produced to you. When

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Dr. Welch's report was produced, we gave you all of the photomicrographs of every single slide he looked at and those were provided to Dr. Weber.
MS. JONES: That's all I'm trying to figure out is what photomicrographs Dr. Weber has actually seen because she can't identify them for me.
MR. SLATER: Dr. Welch had those prepared in his offices at Harvard and then they were provided to me and I bounced them to Dr. Weber. And she had those plus the report to look at. We produced to you all the photomicrographs so you have everything she saw.
MS. JONES: That's fine. I just want to know what it is that she saw. That's all I'm asking.
MR. SLATER: I've produced it to you already. I mean, I can't tell you which specific slides. You have them. You can put them up on a screen and say did you see this. I don't know that she'd be able to say I saw this slide, that slide. She had them all. Everything that I produced to you was given to her electronically. We sent it to her. And we produced it to you on a disk. You have all of them.

And the numbers, I don't have the list of materials reviewed, but I assume the list of numbers is the numbers from the institutions where they identify the path slides. I mean, they have section numbers, whatever you call them.
BY MS. JONES:
Q So that what we're clear on, Doctor, is that the photomicrographs you have gotten are the ones from Dr. Welch?
MR. SLATER: Yes.
MS. JONES: Not from any other institution, not prepared by any other institution? That was my question.
MR. SLATER: To my knowledge, there are no other photomicrographs.
MS. JONES: That's the reason I'm asking the question.
MR. SLATER: Do you have any that I don't know of? Want to throw all our chips into the middle of the table? No, I'm not aware of any. In fact, I just e-mailed my partner to find out if the defense experts prepared any photomicrographs on the slides they looked at because I don't think we were produced any. So I actually just e-mailed Dave Mazie to find out because I don't think we got any

from the defense. They may not have prepared any. I'm assuming they did; otherwise, there's no way to show them to the jury.
MS. JONES: I think we're clear on this now. That's all I want to know is what it is the doctor has seen.
MR. SLATER: The photomicrographs -- what happened was recuts were provided to Dr. Welch. He looked at them. He had micrographs prepared. I don't know the process. It's some sophisticated camera on a microscope or something probably. I can barely work my own camera. And then whatever he prepared was sent to us electronically, provided on disks, we copied the disks, we provided that all to you. And whatever we were provided by Dr. Welch, we bounced it to Dr. Weber so she had what we had.
BY MS. JONES:
Q And you have not seen anything other than the photomicrographs --
A Correct.
Q -- with respect to the pathology?
And, Doctor, have you attempted, based upon those photomicrographs, to look at it and come to any diagnostic conclusions based upon review of those photomicrographs?

A Can you help me understand what you mean by a diagnostic conclusion?
Q For what purpose did you look at the photomicrographs?
A To correlate them with the findings of Dr. Welch.
Q Of Dr. Welch?
A Dr. Welch.
THE WITNESS: Did I speak correctly?
MR. SLATER: Yeah.
BY MS. JONES:
Q Prior to receiving the report of Dr. Welch and the photomicrographs, had you looked at any of the pathology for Ms. Gross?
A No.
Q Had you expressed any opinion with respect to the pathology for Mrs. Gross prior to seeing Dr. Welch's report?
A No.
Q Is it a fair assumption that you rely upon Dr. Welch for any of your opinions with respect to the pathology?
A Yes.
Q So that you don't have independent opinions on the pathology beyond what Dr. Welch

reported?
A Correct.
Q And is the same true with respect to Dr. Serrato?
A With respect to the ultrasound findings you mean?
Q Yes.
A Yes, correct.
Q And is there anything in Mr. Provder's report upon which you rely in forming your opinions?
A Yes.
Q What is that?
A On his assessment of her level of disability and inability to return to her profession.
Q And you understand that she is a nurse by profession?
A I understand that.
Q Would you agree that pudendal neuralgia is a pain syndrome?
A Yes.
Q Can you tell me what the symptoms of pudendal neuralgia are?
A There are several characteristic symptoms that will vary from patient to patient. Pain in the

distribution of the pudendal nerve, pain that's worsened with sitting, pain that may be relieved by standing or lying down. That's all.

Q Are you familiar with a burning sensation being associated with pudendal neuralgia?

A Neuropathic pain is often described by the patient as having a burning character.

Q How about numbness?

A Numbness is not strictly a symptom of pain, a characteristic -- a description of the patient's pain experience.

Q Well, maybe I wasn't clear. I was asking really about symptoms of the pudendal neuralgia.

A No, I don't think numbness would be a characteristic typical of pudendal neuralgia.

Q Are you familiar with feelings of a lump or foreign body in the vagina or rectum associated with pudendal neuralgia?

A It can be.

Q How about abnormal temperature sensations like flushing?

A As a response to the pain itself. Maybe you can clarify for me. Are you talking about the symptoms specific to pudendal neuralgia or the symptoms the patient may experience as a result of

the pain of the pudendal neuralgia?

Q I'm really just talking about symptoms that have been reported in association with pudendal neuralgia.

A Okay. So, no, I would say apart from an association or an event associated with the patient's pain, an abnormal flushing feeling would not be a typical symptom of pudendal neuralgia.

Q How about constipation?

A Again, not specific as a typical symptom confined to pudendal neuralgia itself.

Q How about pain or straining with bowel movements?

A Well, that is in the distribution of the pudendal nerve so that would be consistent, not straining per se but pain.

Q How about straining or burning with urination?

A It's possible, again, with the distribution of the pudendal nerve.

Q How about a sense that the bladder is not empty or never empty?

A Again, possible based on the distribution.

Q How about low back pain?

A No, I don't think that would be typical.

Q How about painful intercourse?

A Again, as a result of the distribution of the pudendal nerve in the vaginal area, yes, pain.

Q How about musculoskeletal pain in other parts of the pelvis?

A You mean other parts than the distribution of the pudendal nerve?

Q Right, right.

A Okay. So that answer would be no.

Q Would be?

A No.

Q So that I understand that last answer, you don't think that pudendal neuralgia is or can be accompanied by musculoskeletal pain in other parts of the pelvis?

A Well, let me see if I can clarify that. The pain of pudendal neuralgia can lead to pelvic muscle spasm. And pelvic muscle spasm can occur on both sides of the pelvis, the side on which the pudendal neuralgia exists and also on the other side.

Q Can you see pudendal neuralgia and pelvic floor dysfunction together?

A Well, what do you mean by "pelvic floor dysfunction"?

Q Well, I said that because I was listening to you talking about pelvic spasms. If you had some dysfunction of the pelvic floor musculature, could you see that in conjunction with pudendal neuralgia?

A Yes.

Q And in the course of your practice, Doctor, did you regularly treat pudendal neuralgia?

A No.

Q If somebody came in with what you diagnosed as pudendal neuralgia, would you refer them out?

A I would evaluate the patient from a urogynecologic perspective and offer the patient what I felt was appropriate on that basis. If I felt that there were contributors or possibly the entire etiology outside of my scope of urogynecology, then I would either -- if I felt there was a contribution, I would refer her and work in conjunction with the referring -- with the doctor to which I would refer her. If I felt it was entirely outside the scope of urogynecology, then I would simply refer her.

Q What is your understanding are the causes of pudendal neuralgia?

A Well, there are several: Trauma; in some

people situations where they are sitting specifically, for example, on a bicycle or a motorcycle, whether it's the pressure of them sitting on that position or the vibration, say, of a motorcycle engine, there is that association; surgery, of course.

Q We talked earlier already about different forms of prolapse surgery that might be associated with pudendal neuralgia, but has hysterectomy been associated with pudendal neuralgia?

A No, hysterectomy by itself, no.

Q What about childbirth or difficult deliveries?

A Yes, that would be possible.

Q Infections in the pelvic floor?

A Infections in the pelvic floor? You mean --

Q Or infections in the pelvis.

A In the pelvis. No, I have not heard that as being a cause of pudendal neuralgia.

Q And when a patient presented to you with symptoms that you thought might indicate pudendal neuralgia, how would you go about making that diagnosis?

A I would obtain her history, see if there

were any identifiable factors that may have caused or contributed to this situation. I would ask her for a very detailed explanation or description of her pain: The location; any factors that relieved it or exacerbated it; the nature of the pain, any describing words that she could give me; the duration; a complete history related to the pain; and then any other points of her history that could potentially be relevant; and then an examination in the pelvic area to map the distribution of her pain to see if it was consistent with the distribution of the pudendal nerve; and then an external examination to see if that reproduced her pain or exacerbated it; and then an internal examination to see if there was any other information that I could gather as to the location or the reproducibility of the pain with examination.

Q And what type of treatment would you prescribe?

A Again, this is where -- once I had a better understanding of the possible cause where I would be likely to involve a second physician. A pudendal -- a nerve block -- I could administer a pudendal nerve block in the office. And that has both a diagnostic and a therapeutic effect if she

experiences pain relief. It's diagnostic in the sense that if she experiences pain relief, that's a very strong indication, what many doctors feel is the strongest indication, that you are, in fact, dealing with pudendal neuralgia; and then therapeutic obviously in the sense that if her pain is relieved, she feels better.

Q And did you actually when you were practicing perform pudendal nerve blocks?

A Not in my -- during my residency, yes; not since then.

Q During your residency between '88 and '92?

A Correct.

Q Would that have been the last time that you've treated pudendal neuralgia?

A Yes.

Q Other than the nerve block, is there any other type of treatment that you would have prescribed for pudendal neuralgia that you can remember?

A I would not. At that point I would involve another physician with expertise.

Q In the case of Ms. Gross, is it your opinion that the surgery that she had for prolapse caused the pudendal neuralgia or is it the use of

mesh that caused the pudendal neuralgia?

A I think it is most likely that the pudendal neuralgia was caused by the proximity of the mesh itself. I can't rule out the possibility of a contributing factor that occurred during the surgery.

Q And can you tell me why you think it is most likely to be the proximity of the mesh itself? The proximity of the mesh to the nerve?

A Correct.

Q And why do you reach that conclusion?

A I am not sure I understand your question. Why --

Q Why is it that you believe that it's the proximity of the mesh to the nerve that's caused the neuralgia as opposed to the surgery itself?

A I think if Mrs. Gross had had a direct very traumatic injury, such as the trocar passage through the pudendal nerve, that would have been immediately evident when she was woken from anesthesia. I think it's possible that she had a less severe injury due to trocar passage. As I said, I can't rule that out.

After surgery then it's the mesh placement, the inflammatory and foreign body

reaction that it causes, the fibrosis and scarring in very close proximity to the nerve, if not on the nerve, that led to her pudendal neuralgia.
Q And did you review the medical records of Ms. Gross to determine whether or not she had experienced any signs or symptoms before the surgery that might be indicative of pudendal neuralgia?
A Yes.
Q Did you find any?
A No.
Q So when you went back and looked at the records, you did not find that she had experienced any symptoms that had been associated with pudendal neuralgia?
MR. SLATER: You're talking about prior to the surgery?
MS. JONES: Prior to the surgery.
THE WITNESS: I didn't find any evidence that she had symptoms of pudendal neuralgia before the Prolift® surgery.
BY MS. JONES:
Q Did you find that Ms. Gross had a prior history of stress urinary incontinence?
A Yes.
Q Of obstructed defecation?

A Those were her symptoms, yes.
Q And had a rectocele?
A Yes.
Q Ms. Gross had also had several pregnancies, had she not?
A Three.
Q There were some difficult deliveries?
A What do you mean by "difficult"?
Q Well, she had a fourth-degree vaginal tear, didn't she?
A Actually in reading the doctor's delivery note, he cut the fourth-degree to make room for the delivery of the fetus.
Q Had she had any pelvic spasms of which you're aware?
A Pelvic muscle spasm?
Q Uh-huh.
A No, not to my knowledge.
Q So do I understand your opinion, Doctor, to be that Dr. Benson's use of trocars in the Prolift® surgery did not likely cause the pudendal nerve injury?
A I can't rule it out.
Q Do you have any opinion as to whether or not Dr. Benson's surgical technique was incorrect in

any way?
A His surgical technique was not incorrect based on his operative report. The trocar passages themselves introduce an unreasonable degree of risk of nerve damage specifically along with other types of damage in the Prolift® procedure.
Q My understanding, though, from what you testified earlier, and I'm just asking, is that if Ms. Gross had experienced nerve damage as a result of the use of the trocars, you would have expected to have seen that immediately?
A Direct severely traumatic as in driving the trocar right through the nerve. Also, the pudendal nerve at various places, because everyone's anatomy is different, branches into its three terminal branches. It's possible that one of the smaller branches was directly injured. As I said, I cannot rule it out.
Q I understand that you can't rule it out. But am I correct that even though you say you can't rule it out, your belief and position as you sit here today is that the nerve damage was not as likely due to the trocar as it was to the placement of the mesh?
A Correct.

Is this a good time for a break?
(Discussion off the record.)
MS. JONES: Can we go ahead until we get lunch?
THE WITNESS: Yes.
BY MS. JONES:
Q Are you aware, Doctor, of any place in the medical records where there's any mention or discussion of pudendal nerve damage prior to August of 2007?
A Can I look at my report, please?
Q Yes.
MR. SLATER: Yeah, sure. I have it on the floor here.
BY MS. JONES:
Q Doctor, I'll tell you where I think it is. I picked that up on Page 6 of your report. And my note says the first mention of pudendal nerve damage as a cause of the symptoms was recorded on August 29th, 2007.
A Okay. And that's on Page 6?
Q I have it marked on Page 6. That's what I took my notes from.
THE WITNESS: Can I ask you a question? Should we step out or can I just ask you?

MR. SLATER: No. Don't ask me anything. I mean, if there's something missing from this notebook, then I have to just get someone to bring it in. The page number may just be a typo or something on her outline.

MS. JONES: It may be. I promise this is not a trick. I have my notes.

THE WITNESS: Yeah, I just -- I don't see what you're saying.

BY MS. JONES:

Q I don't see it on Page 6 either. I've obviously got a typo on it.

MR. SLATER: Off the record.

(Discussion off the record.)

BY MS. JONES:

Q All right. Doctor, while we were off the record, it is on Page 5 that you note in your report that the first mention of pudendal nerve damage as a cause of Ms. Gross' symptoms was on August 29, 2007; correct?

A Correct.

Q And you mentioned that you had treated pudendal neuralgia in your residency. Was it in medical school or in the residency that you were taught the distribution of the pudendal nerve?

A Both.

Q And were you taught to do the pudendal nerve block in your residency or in medical school?

A I certainly learned it in my residency. I don't remember if I learned it in medical school also.

Q You testified earlier that pudendal nerve damage can be the result of the sacrospinal ligament fixation?

A Correct.

Q And my question is, how is it caused by that surgery?

A Typically it's an entrapment where the suture -- in a sacrospinous ligament fixation, the surgeon is approaching the sacrospinous ligament from its superior aspect. And the pudendal nerve in relation to the ischial spine and the sacrospinous ligament is in very close proximity in such a way that a suture can be passed into the substance of the sacrospinous ligament and entrap the pudendal nerve.

Q Would you say that again, please?

A Do you want me to rephrase it or --

Q No, no, no. I just -- I think my mind went in and out just for a second. I just don't

think I caught the last of what you said about how it could -- I know we talked about the approach, but tell me how it entraps the nerve.

A So the superior surface of the sacrospinous ligament, the ischial spine, and the pudendal nerve are all in very close proximity. The surgeon in passing a suture through the superior aspect of the sacrospinous ligament may inadvertently include the pudendal nerve in that suture, entrapping it. It's called pudendal nerve entrapment.

Q And it's that type of entrapment that's generally the cause of pudendal nerve neuralgia in the sacrospinal ligament fixation surgery?

A Correct.

Q The surgery that Ms. Gross had on the pudendal nerve was in June of 2009; correct?

A Yes.

Q And it was performed by Dr. Hibner?

A Yes.

Q At the time that Dr. Hibner performed that surgery, he did not find the presence of mesh, did he?

A There's conflicting information on that point. The operative note which he dictated

immediately after performing the operation has a description of mesh attached directly to the pudendal nerve. Under testimony Dr. Hibner testified that he did not believe it was mesh; if it were mesh, he would have sent it for pathology, and he did not send it for pathology and he believed it was scar tissue.

Now, in terms of causing Mrs. Gross' pudendal neuralgia, whether it was mesh or not, according to Dr. Hibner's conflicting information, she had pudendal neuralgia on the basis of the mesh implantation near or -- adjacent to or touching the pudendal nerve in such a way that the inflammatory body reaction, the scarring, the fibrosis from the Prolift® mesh implantation was responsible for her pudendal neuralgia.

Q Have you seen any pathology that shows that mesh is in any of the scar tissue around the pudendal nerve?

A As I understood from Dr. Hibner's testimony, he did not send that specimen for pathology.

Q And you've not seen any pathology from any other surgery or any other findings that mesh was actually removed from the pudendal nerve?

A Again, to my understanding from Dr. Hibner's testimony, that wasn't sent for pathology. You wouldn't take -- even if he had taken mesh off the pudendal nerve, unless he excised the pudendal nerve or a part of it, that would not show up in the pathology specimen.

Q You wouldn't send an encased mesh to pathology?

A According to my understanding of the operative note, mesh or scar -- mesh, that's in the operative note, Dr. Hibner's testimony, scar tissue was found attached to the pudendal nerve. The goal of the operation, of course, is to leave the pudendal nerve intact. If you excise a portion of the pudendal nerve and send it to pathology, the patient is obviously going to suffer from that excision.

Q My question was really a little different, Doctor. If you as a surgeon excised tissue in which mesh was encased, would you have sent that to pathology?

A Yes.

Q And would you think that that would be the standard of care for a surgeon to send that material to pathology?

A I was taught to send all material to pathology. You take it out of the patient, you send it to pathology. I can't really speak to what every other surgeon does.

Q That's what you would have taught your residents and fellows when you were involved in academic medicine?

A Correct.

Q I take it that it's your position that Ms. Gross would not have had pudendal nerve neuralgia but for the use of Prolift®?

A Correct.

Q Have you seen any medical literature specifically that relates to Prolift® and pudendal nerve involvement?

A No.

Q Mrs. Gross had mesh removed and the Prolift® removed in early 2007, did she not?

MR. SLATER: Objection to the form. You can answer.

THE WITNESS: The date again, please?

BY MS. JONES:

Q I confess to you, Doctor, I'm looking for the exact date. I don't have it in my notes. In December, December 14 of 2006,

Dr. Benson performed a surgery to excise the Prolift® vaginal mesh; correct?

A To my understanding, he was concentrating on the anterior portion of the Prolift® mesh at that surgery.

Q And subsequently Ms. Gross had other portions of the Prolift® removed; correct?

A Yes.

Q Did Ms. Gross suffer from interstitial cystitis?

A In my opinion, no.

Q What's that opinion based upon?

A That opinion is based upon the -- my understanding of the course of interstitial cystitis and how that did not match up with Linda Gross' course.

Q Tell me what you understand the typical course of interstitial cystitis to be.

A Well, first I'll explain interstitial cystitis is a collection of symptoms. In its severe form that leads to cystoscopic findings, it is a chronic disease or condition with symptoms of urgency, frequency, and bladder pain that occur over the course of months and years. Mrs. Gross didn't have a diagnosis of

interstitial cystitis before she had the Prolift® placed. I believe it was approximately two months after the Prolift® procedure Dr. Benson performed a cystoscopy and described findings that he attributed to the possibility of interstitial cystitis. On subsequent cystoscopies those findings were not repeated.

So on that basis she didn't have it before, she had one cystoscopy two months after the surgery at a time when she was experiencing urinary tract infections, retention -- and urinary retention, and the cystoscopic findings were never seen again on subsequent cystoscopies.

Q You told us yesterday that you had spoken with one of the other plaintiffs' experts with respect to interstitial cystitis; am I correct?

A Yes.

Q And who was that?

A That was Dr. Elliott.

Q And did you speak with Dr. Elliott specifically about the diagnosis of interstitial cystitis in Ms. Gross?

A I can't remember.

Q Does Dr. Elliott, if you know, have a more extensive background in the treatment of

interstitial cystitis in women than you do?
A Yes, I would presume so.
Q In your practice, Doctor, did you regularly treat women with interstitial cystitis?
A No.
Q Do you know how many women you actually treated with interstitial cystitis?
A No.
Q After you completed your residency, did you treat anyone with interstitial cystitis?
A I'm sure I saw patients with a history of stable interstitial cystitis. I did not treat patients with bladder distillation or hydrodistention or any other form of that kind of treatment.
Q And would you regularly refer people with those conditions to urologists?
A Yes.
Q Are there sources of inflammation in the pelvic floor other than mesh, for example?
A In the pelvic floor?
Q Uh-huh.
A The pelvic musculature? Source of inflammation. Certainly, muscles can be inflamed for reasons other than mesh.

Q For example, could you have inflammation associated with muscle spasms or tension? And let me say muscle spasms or tension in the pelvic floor muscles, the musculature.
A So are you asking whether inflammation is the starting point and then it's associated with the development of pelvic muscle spasm?
Q No. I'm asking whether or not muscle spasms or tension in the pelvic floor muscles can be a source of inflammation, can lead to inflammation.
MR. SLATER: Are you talking about generalized inflammation or any particular inflammation?
MS. JONES: Just inflammation.
MR. SLATER: Objection.
You can answer.
THE WITNESS: Not to my knowledge.
BY MS. JONES:
Q During the course of your practice, Doctor, did you treat patients with pelvic floor muscle pain?
A Yes.
Q And what type of treatment did you prescribe for those patients?
A Well, in her history I would look for any

causative or contributing factors that could be addressed by behavioral or lifestyle changes, if something was triggering the pain specifically. If there weren't any known triggers that I could address, then it's empiric treatment for muscle relaxation. I would start with physical therapy. I would add pharmacologic therapy if needed.
Q And would you follow the same process with respect to myofascial pain?
A Myofascial pain is -- myofascial pain is used synonymously with pelvic muscle spasm.
Q With muscle spasms?
A Pelvic muscle spasm, hypertonicity, levator myalgia. There isn't one name for this condition.
Q I understand. When you said synonymously, it threw me off a little bit, because I thought you said that muscle spasms were synonymous with myofascial pain. Maybe I misunderstood.
A Well, myofascial pain is not specific. That could be any muscles in the body. So are you talking about pelvic myofascial pain?
Q I am.
A Okay. So then it's possible you could have pelvic muscle spasm without pain. But if you

have pelvic muscle spasm and pain, that would be used interchangeably with pelvic myofascial pain.
Q Are there other sources of pelvic myofascial pain other than muscle spasms?
A Sure. Anything that can happen to a muscle. You can strain it. You can bruise it, I suppose. You could -- it could be traumatized in some way.
Q Can stress trigger myofascial pain?
A Like emotional stress?
Q Yeah.
A As opposed to physical stress?
Q Well, physical stress could obviously trigger it; right?
A Right.
Q Could emotional stress?
A Emotional stress. It could certainly exacerbate it. It could trigger it if a woman for some reason was adding an element of voluntary contraction -- muscle tension, of course, anywhere is a very common reaction to stress so I don't see any reason why it couldn't affect the pelvis.
Q Is it your opinion, Doctor, that Ms. Gross benefited from pelvic physical therapy?
A After her surgery to treat her pelvic

muscle spasm? Is that what you're referring to?
Q No. You know that she did receive some physical therapy and pelvic floor tone and relaxation physical therapy, do you not?
A Yes. So that would be after her surgery to treat her pelvic muscle spasm; no?
Q And it was recommended that she participate in a pain management program, wasn't it?
A That was offered to her as an option.
MR. SLATER: Just so you know, lunch is here.
MS. JONES: Okay.
BY MS. JONES:
Q Is it your judgment that she would benefit from participation in a pain management program?
A I don't know.
MS. JONES: Let's stop and have lunch.
(Luncheon recess taken from 1:13 p.m. to 2:34 p.m.)
(Exhibit No. 1220 was marked for identification.)
BY MS. JONES:
Q We have marked as Exhibit 1220 the list of materials reviewed. Doctor, have you reviewed this?

A Have I reviewed that document?
Q Yes, ma'am.
A Yes.
Q And I understand that over the lunch hour this was changed and the deposition of Dr. --
MR. SLATER: Antolak.
BY MS. JONES:
Q -- Antolak was added to this?
A Correct.
Q And also a video of some explantation was added to this?
A Yes.
Q Is there anything else that you have reviewed that's not on this document?
A No.
Q Did you actually review the deposition of Dr. Antolak over the lunch hour?
A I skimmed it, yes. I skimmed it.
Q Did you skim or review any other materials over the lunch hour?
A The most recent follow-up on Mrs. Gross after having had her first Botox injection.
Q Anything else?
A No.
Q According to the financial disclosure that

your counsel has just provided, you have been paid a total of $328,647 as of October 15, 2012; correct?
A I have no reason to doubt the document. I do not know the number off the top of my head.
MR. SLATER: I can represent to you this was the accurate number as of the date of disclosure. There have been subsequent invoices; it's just not updated.
BY MS. JONES:
Q Have there been subsequent invoices since October 15?
A Yes.
Q How frequently do you invoice plaintiffs' counsel?
A Once a month.
Q What was the date of the last invoice?
A November 1st.
Q Do you know for what amount that was?
A I don't.
MS. JONES: Counsel, can you tell me?
MR. SLATER: I can find out. I don't know off the top of my head, but I'll find out the amount.
BY MS. JONES:
Q This indicates that your hourly rate

became $350 an hour in July of 2012; is that correct?
A Again, I don't have any reason to doubt that. I don't recollect that myself.
Q You recollect and I think you testified that you increased your hourly rate from 250 to 350 dollars an hour, didn't you?
A Correct.
Q So that we would have to go back and actually get the underlying invoices to see when you changed that hourly rate?
A Well, I believe you just identified that as occurring in July 2012.
Q No. That's what I asked you and you told me you didn't know.
A I do not remember exactly when that happened. If you want confirmation beyond what's in front of you, yes, we could go back to the individual invoices.
MR. SLATER: And I'm representing to you that is when it happened.
BY MS. JONES:
Q Have you changed your hourly rate for review of the medical literature as a medical writer?

A No.
Q So that remains $250 an hour?
A Yes.
Q What prompted you to change this rate to $350 an hour?
A I felt with my growing experience and expertise over the past almost three years of reviewing the documents and so on that that added experience increased the value of my time.
Q At any time, Doctor, have you totaled the amount of the invoices to confirm that what you've been paid is $328,000-plus?
A No.
Q Since October 15 approximately how much time have you spent in this litigation?
A Not including the time since I arrived in New Jersey?
Q Well, let's divide it up. Before you arrived in New Jersey.
A I would say between 30 and 40 hours.
Q Since October 15th?
A I don't like to guess.
Q My recollection is that you testified yesterday that you had spent approximately 30 hours a week the last several months preparing for this

deposition and the reports and so forth.
A Well, I'm still guessing, but a better guess would probably be between 50 and 60 hours.
Q And when did you arrive in New Jersey? That's before you came to New Jersey?
A Correct.
Q When did you come to New Jersey?
A Saturday about noontime.
Q And since that time, since the time that you arrived in New Jersey, how many hours have you spent?
A On Saturday Adam and I worked until about 6:30. And then I went to the hotel and worked for perhaps two hours. On Sunday --
Q So that would have been a total of how many hours? Eight hours?
A Approximately. On Sunday Adam and I worked together for about eight hours and then in the evening I worked for about three hours, so that would be 11 hours.
Q And then yesterday you had how much time?
A Yesterday I worked in the morning for about two hours. And then we had the deposition. And then I worked in the evening for about half an hour.

Q So that would have been roughly ten and a half hours?
A Yes.
Q And today did you work any before you came here for the deposition?
A Yes. I worked this morning for about an hour.
Q And how do you charge for your travel?
A We haven't discussed that yet.
Q You expect your expenses to be reimbursed, I assume?
A Yes.
Q And you expect to be compensated for your time and travel?
A Yes.
Q Before we took a lunch break, we were talking about whether or not Ms. Gross would benefit from a pain management program. Do you remember that?
A Yes.
Q Have you seen or do you know of the success of programs such as the Mayo Pain Clinic program in treating pelvic pain?
A I do not know.
Q Do you believe that Ms. Gross would

benefit from pain management?
A Are you referring specifically to this program now or pain management in general?
Q In general.
A I believe she may benefit. She would hopefully benefit.
Q You would agree that one's perception of pain can be influenced by one's psychological well-being?
A Yes.
Q If you were treating Mrs. Gross today based upon what you know, what treatment, if any, would you prescribe for her?
A As under what realm? As a urogynecologist?
Q If Ms. Gross walked into your office today with what you understand to be her current medical condition, is there any treatment that you would prescribe to her?
A Well, of course, I would take her history, which is already very familiar to me, but I would make sure I understood that from her standpoint, especially in terms of her current symptoms. I would perform an examination. I would determine what aspects of her condition I may able to address,

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what additional consultations would be beneficial in her overall management. And I would go from there.
Q As you sit here today, do you have any opinion as to what other consultations would be beneficial to her in her overall management?
A She has a pain management specialist. She has her family practitioner. She sees urogynecologists. She's receiving psychological counseling. She sees a urologist. She undergoes physical therapy. I can't think of any other consultations that I could offer her at this time.
Q Is there any medical treatment that you as a urogynecologist would offer her today?
A Well, to the extent possible, considering her conditions are now more likely than not permanent, I think she's receiving the -- unless something new happens, her current management I think is addressing all of her issues and offering her what there is available, although limited, because she's not in a state where cure is a possibility for her, she's in a state of palliation.
Q What is your prognosis or what is your opinion as to her prognosis if you have one?
A Specific to any one of her conditions or all of them?

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Q To any condition about which you've been asked to opine.
A I believe that her condition, while it may wax and wane within a certain restricted range over time, is otherwise permanent.
Q And when you say her condition is permanent, will you describe for me what condition it is that you believe is permanent?
A I believe her pain is permanent. It's possible she may experience some relief, not likely resolution of the pelvic muscle spasm component of her pain. I believe her urinary retention is permanent and she will require intermittent self-catheterization for the rest of her life. To the extent that she has mesh remaining, she remains at lifelong risk for mesh-related complications like mesh erosion.
Q Do you have any evidence that she, in fact, has mesh remaining in her body?
A To my knowledge, there are at least pieces of the six mesh arms that were implanted in Linda.
Q And have you done anything in any way to quantify the amount of mesh, if any, that's left?
A No, that's not possible. Ultrasound can visualize mesh -- can visualize mesh.

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Q Is there anything other than the ultrasounds upon which you rely for your opinion that there are some residual pieces of mesh?
A To my understanding of the operative reports, specific areas, such as the placement of the two superficial anterior arms through the obturator space and the two deep anterior arms through the obturator space and the two posterior arms through the ischiorectal fossa, have not been specifically sought with the idea of removing them.
In fact, Mrs. Gross has been informed that it would be -- it would introduce additional morbidity. And her husband, Mr. Gross, had a very insightful observation: If it's too difficult to remove the mesh that was implanted, how is -- or too dangerous, how is it not too dangerous to implant it in the first place?
MS. JONES: Move to strike as nonresponsive.
BY MS. JONES:
Q Are you relying upon his deposition or have you spoken with Mr. Gross?
A I have not spoken with Mr. Gross.
Q Have you reviewed the reports of the defense experts with respect to Ms. Gross?

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A Yes.
Q Which reports have you reviewed?
A Kavaler, Minkin. I believe those are the two that are specific to Mrs. Gross.
Q Do you have any opinions or disagreements with either of those reports?
A Yes, I do.
Q Can you tell me what they are?
A Can I have the report, please?
Q If you have it with you.
MR. SLATER: Well, I can go have somebody print copies. You don't have them?
MS. JONES: I'm asking for the disagreements with the report.
MR. SLATER: I understand. She's saying she needs to be able -- they're lengthy reports. What she's going to likely do now is go page by page for probably an hour or two. I'm not being facetious. I can go get them printed, but if the question's going to be to list all her disagreements --
BY MS. JONES:
Q Have you, in fact, prepared a report listing all your disagreements?
A I have made comments.

Q Where did you make comments?
A In a document.
Q In what document?
A I don't remember the title. It's not a report as in those reports of mine.
Q It's not a report that's been furnished to us?
A Correct.
Q Let me ask you, Doctor, to summarize if you can your disagreements with those of Dr. Kavaler.
A I really prefer to have the report in front of me.
MR. SLATER: I'm going to go get someone to print it.
THE WITNESS: Because my criticisms are very specific and I'll do a much better job when I have the report in front of me.
BY MS. JONES:
Q So as we sit here today, you really don't remember what those criticisms are?
MR. SLATER: That's unfair. I object. You asked her to list her criticisms. And any competent and reasonable witness and attorney would want to have the document in front of them in

order to answer the question when Kavaler's report is nearly 50 pages long, Minkin wrote two lengthy reports. So she has the right to have the document in front of her if you're going to ask her any questions about the document; right? So I'm going to get them.
MS. JONES: I'm asking her questions about her opinions, counsel.
MR. SLATER: You're asking what?
MS. JONES: I'm asking her questions about her opinions. I asked her to summarize those opinions. I think I'm entitled to an answer to that.
MR. SLATER: You're going to get an answer. You object to me putting the reports in front of the witness?
MS. JONES: I don't have any objection to it.
MR. SLATER: So I'll go get them.
MS. JONES: But I think that's the reason we ask you to bring documents with you.
MR. SLATER: Hang on. Hang on. With all due respect, you're taking a deposition, you're asking questions of the witness about documents you didn't bring. The customary thing that we do is if

you're going to ask someone about a document, give it to them and say, here, I'm going to ask you some questions about the document.
So we'll take a break. I'm going to go get those two reports. And, counsel, you have the materials reviewed. You know that she saw all the expert reports. It's all listed. I'll go get those two reports because that's your particular question. It's actually three reports. Take a break while I get them.
(Short recess.)
MR. SLATER: So I have given her the reports now.
BY MS. JONES:
Q Okay. I have a question before you go through the reports, Doctor. You said that you had prepared a document critiquing these reports for Mr. Slater?
A Yes.
Q Did you review that report in preparation for this deposition?
MR. SLATER: Objection to the form.
You can answer.
THE WITNESS: Considering the defense expert reports were only served on October 15th, it

has been in the past couple of weeks. I don't know that I reviewed it specifically in preparation for my own deposition.
BY MS. JONES:
Q Have you reviewed that document since you arrived here on Saturday?
A No.
Q When did you actually prepare it?
A I don't know. Sometime after October 15th.
Q Sometime in the last two to three weeks anyway?
A Correct.
Q Now, what I would like you to do is to summarize for me your criticisms or disagreements, however you choose to characterize it, with Dr. Kavaler.
A A general summary of my opinions is that she does not address all the issues of substance, she makes misleading and inaccurate statements, and her opinion -- I disagree with the opinion -- her opinions as to the causation of Mrs. Gross' injuries.
Q Do you know Dr. Kavaler?
A No.

Q Ever met her?
A No.
Q Know anything about her practice beyond what you know in the report?
A I think I Googled her once her report was provided to me.
Q Ever read any of her publications?
A No.
Q When you said that she did not address all of the material aspects of the case, what areas do you believe she failed to address?
A She failed to address, among many other things, Ethicon's failure to warn physicians and patients of the material risks, many of which affected Linda Gross directly, like the risk of urinary retention.
In fact, Dr. Robinson right before he joined Ethicon was so alarmed about the extent and severity of urinary retention that he was seeing in his patients and in other -- the patients of other physicians with whom he was in contact when he first arrived at Ethicon, he felt strongly that he wanted to include a specific warning in the Prolift® IFU about the risk of this prolonged and severe urinary retention.

This was discussed. Opinions from experienced Prolift® users were taken -- were obtained urgently at a meeting. They didn't know what caused this. Ethicon didn't study it. They drafted something to be put into the IFU and it never made it into the IFU. So physicians and patients went unwarned of this severe risk after the Prolift® procedure.
MS. JONES: Move to strike as nonresponsive.
BY MS. JONES:
Q Doctor, other than the risk of urinary retention that you believe that Dr. Kavaler failed to address, are there other issues that you believe she failed to address?
MR. SLATER: Objection to the form of the question.
You can answer.
THE WITNESS: She failed to address Ethicon's failure to warn of the risk of complications after the Prolift® procedure that were untreatable.
BY MS. JONES:
Q Such as?
A Such as chronic pelvic pain, mesh

exposure -- mesh erosion and recurrent mesh erosion that could not be resolved, vaginal anatomic distortion and scarring that could not be addressed in a way that a woman was able to engage in normal sexual relations, to name a few.
Shall I keep going?
Q Anything else that you believe that she failed to address that she should have addressed in this context.
A She failed to address Ethicon's failure to warn that patients on anticoagulation therapy are contraindicated to undergo the Prolift® procedure. This was another warning that Ethicon had placed in its instructions for use, for example, for the TVT®, which is only two trocar passes, and yet in the Prolift® procedure with six trocar passes through the deep pelvis a warning was not added. It was considered. And Ethicon, for reasons that are inexplicable to me, never made that change.
There was a warning that Axel Arnaud wanted to include in the Prolift® IFU right before Prolift® was getting ready to launch about pelvic pain and pain with intercourse. And this warning was not added to the IFU because the IFUs had already been printed and the change -- Ethicon

didn't want to make the change and reprint the IFUs.
MS. JONES: Move to strike as nonresponsive.
BY MS. JONES:
Q What other areas do you believe -- and I'm just asking you to list them -- that Dr. Kavaler failed to address?
MR. SLATER: And just for the record, you want her to just go off the top of her head and list generally? She has the report here.
MS. JONES: She's got the report in front of her. I'm just asking her --
MR. SLATER: You can keep listing off the top of your head and then eventually you can sit down and go through the report if you want to if counsel wants the complete list.
THE WITNESS: One more thing is that Dr. Kavaler failed to address the failure of Ethicon to properly study Prolift® before launch in a way that would allow for appropriate patient selection, and that includes patients with preexisting pain conditions, when it was learned only later that these patients would have an -- or were at higher risk to have an exacerbation of their preexisting pain condition or the development of a new pain

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condition such that implantation of the Prolift® was contraindicated in them, that they could develop complications that were untreatable, that left them with devastating, life-altering complications for which there is no treatment.

Dr. Kavaler failed to address the fact that Ethicon failed to study the complications that were known and foreseeable that would occur with the Prolift® procedure. And they failed to include this in their internal design processes which, if they had performed properly, the Prolift® would have never reached the market.

MS. JONES: Move to strike as nonresponsive.

BY MS. JONES:

Q Do you know, Doctor, whether or not Dr. Kavaler actually used the Prolift®?

A I believe she stated so in her report.

Q She actually had experience using Prolift® with her patients, did she not?

A Evidently. I just answered that. I'd like to continue to address your previous question.

Q Other things that you say she left out?

A The other disagreements I have with her opinions.

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Q Let me separate these if I can, because I thought that we were talking about first and I thought my question was first what is it that you believe that she left out and didn't address, because that was where you started first.

A Well, what you asked me first was what I did I disagree with in her report. And on Page -- give me just a second.

Okay. So on Page 69 she is addressing the -- she is addressing -- she's making a counterpoint to my opinion in which she states: Ethicon adequately warns about the risk of nerve damage in its Prolift® IFU and patient brochure.

And in other places in her report she opines that Ethicon's Prolift® IFU adequately warned of the risks. So what I was doing was providing you with my opinion in contrast to that that Ethicon did not adequately warn of the risks in its Prolift® IFU.

So now shall I continue with my disagreements with her opinions?

Q I would like to hear all of your disagreements. Before we spend time doing that, let me ask you this: Are there any disagreements with her opinions that are not set forth in your report?

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A Yes.

Q What are they?

A On Page 27, No. 3, Dr. Kavaler claims that Mrs. Gross has recurrent prolapse. She did not have recurrent prolapse. Her opinion is that Prolift® was an appropriate choice to treat her bothersome recurrent prolapse. And, again, she does not have recurrent prolapse.

Prolift® is a safe and effective treatment of pelvic organ prolapse. I do not agree with that.

Q Let me make myself clear. Maybe my question wasn't clear. The opinion that you have about Prolift® is set forth in your report, is it not?

A Correct.

Q My question is: Are there any opinions that you have in response to Dr. Kavaler that are not set forth in your report?

A Yes.

Q That's what I'm trying to identify is just that discrete group of opinions that you have not previously written about.

A Okay.

MR. SLATER: Just objection to the form.

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You can answer.

THE WITNESS: Page 27, No. 5: Linda Gross chose to undergo so many surgeries after the original implant that it is impossible to attribute her present condition to Prolift®. Many of these surgeries were against the advice of her physician -- physicians.

This is absolutely unreasonable. Mrs. Gross went through the process of multiple surgeries at each time sitting down with her surgeon, discussing her condition, and making a joint decision to go ahead with surgery. She didn't set out to have the number of surgeries she had. She had the number of surgeries she had as a direct result of the Prolift® procedure and the permanent Prolift® mesh implantation. At each time she was faced with the decision as to whether she would undergo surgery again. This was in consultation with her surgeon and under his or her recommendation to go forward because that was a reasonable choice at the time. To suggest --

BY MS. JONES:

Q May I just ask -- let me just ask one question.

MR. SLATER: Don't interrupt her. I

mean, she's in the middle of her answer.
MS. JONES: I just want to ask this question.
BY MS. JONES:
Q Is there documentation in the medical records that surgeons advised her against having further surgery?
A Yes. I would like to expand on that and also complete the answer to the question.
Q I'm perfectly happy for you to complete your answer.
A It is unreasonable and unethical to suggest that Mrs. Gross underwent surgery at any particular instance because no surgeon acting ethically would perform a surgery that he or she did not feel that the possible benefit of that surgery outweighed the possible risks. It would be unethical to do otherwise. To suggest that Mrs. Gross underwent surgery against the advice of her physicians ignores that obvious and very basic, fundamental aspect of the practice of surgery.
Q Are you finished?
A That's the rest of my answer to that question. Shall I continue with the remaining disagreements that I have with Dr. Kavaler that are

not otherwise in my report?
Q I thought that that was what you had just told me you had completed.
A That was No. 5. I was just completing my response to No. 5 on Page 27.
Q Please tell me what else you disagree with that's not otherwise in your report.
MR. SLATER: Objection to the form.
You can answer.
THE WITNESS: No. 6: Linda Gross' current condition is attributable to pelvic muscle spasms. Dr. Kavaler ignores the reality that Linda Gross has pelvic muscle spasm in addition to other conditions. She acts like pelvic muscle spasm is the exclusive cause of the constellation of Linda Gross' symptoms and I do not agree with that.
Prolift® did not -- this is No. 7: Prolift® did not cause pudendal neuralgia in Linda Gross. If Ms. Gross at some time -- excuse me -- at some point developed a pudendal injury, it cannot be attributed to Prolift®, particularly in light of her preexisting history of pelvic floor defect and her extensive history of post-implant surgeries.
The only surgery that Mrs. Gross underwent that specifically addressed her

pudendal -- the pudendal nerve was the surgery that she had with Dr. Hibner, the neurolysis and the combination of procedures that accompanied that. It's ludicrous to suggest that pudendal neuralgia was the result of that surgery when pudendal neuralgia was the indication for that surgery. At no other time did Mrs. Gross undergo a surgery that directly addressed the pudendal nerve or that would place the pudendal nerve at risk for the kind of outcome she had, the pudendal neuralgia, except for the indexed Prolift® procedure and the result of the Prolift® mesh implantation.
No. 8: Linda Gross' incomplete bladder emptying cannot be attributed to Prolift®. I disagree with that opinion and the basis for that is explained in my report.
No. 9: Linda Gross' two mesh extrusions are the result of post-implant surgeries, not her July 2006 implant surgery. I disagree with this opinion. And, again, it is ludicrous to suggest that mesh erosion as a complication can occur unless you have mesh implantation. She had Prolift® mesh implantation, and as a result of that mesh implantation she subsequently developed the complication of mesh erosion.

No. 10, Page 28: The known risks of Prolift® are adequately warned about in the product's IFU and patient brochure. I utterly disagree with this. In -- I'm going to try to confine my remarks to what is not already in my report at your request. Linda Gross read the patient -- the Prolift® patient brochure and she relied on it in making her decision to go ahead with the Prolift®. She believed the false and misleading statements in the Prolift® patient brochure.
MS. JONES: Move to strike as nonresponsive.
MR. SLATER: She's in the middle of her answer.
MS. JONES: I don't care.
BY MS. JONES:
Q I mean, I've asked only for an identification of what it is that you disagree with in the report that's not otherwise set forth in your report. And if you disagree with the statement that they failed to warn, that's all I need.
MR. SLATER: You realize my concern with the question is it's a very difficult thing to say what's in the report, what's not in the report. You know, we're being cautious because we're

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concerned about someone later saying something fell within the crack.
BY MS. JONES:
Q Let's answer this question, Doctor: Have you set forth in your roughly 600 pages of report your opinions with respect to the warnings and the contents of the IFU?
A Yes.
Q Have you set forth in your report your opinions with respect to the warnings and content of the patient brochure?
A Yes. I would like to point out you asked me specifically with regard to Linda Gross and with regard to what's not already in my report. I'm telling you about the patient brochure and what Linda relied on. That's not in my report.
Q Let me ask you this: You're relying upon Ms. Gross' deposition testimony?
A Correct.
So am I allowed to go forward?
MR. SLATER: Just hang on. She'll ask a new question.
THE WITNESS: I thought I was still answering the last question. I thought I was still answering the question where you asked me --

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BY MS. JONES:
Q Is it your intent, Doctor, to walk through every page and every paragraph that Dr. Kavaler wrote in her report and say you disagree with it?
MR. SLATER: Before you answer, I have to place an objection. Just one second.
Counsel, if you ask the question what does she disagree with in Dr. Kavaler's report, I assume you'd want her to go through and tell you everything, so that's what you would expect her to do. It's a bit argumentative and pejorative to kind of say it as if that's something that you wouldn't expect her to do.
BY MS. JONES:
Q Do you disagree with every paragraph in Dr. Kavaler's report?
A I can't make that claim until I, again, go through every paragraph in Dr. Kavaler's report. I was trying to be responsive to your question and you interrupted me.
MS. JONES: Let me take 30 seconds.
(Short recess.)
BY MS. JONES:
Q Doctor, in the interest of time and because I would really like to finish this

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deposition today, I am going to withdraw my question to ask you to go through and outline the various disagreements with Dr. Kavaler.
Let me ask you this question: Have you reviewed the report of Dr. Minkin?
A Yes.
Q Have you reviewed the report of Dr. Stevens?
A Yes.
Q In the document that you prepared with your comments about these reports for Mr. Slater, did you include in there comments about Dr. Minkin and Dr. Stevens?
A I don't recall making comments about Dr. Stevens' report.
Q In your report and opinions we talked about, you have said that you believe that Ms. Gross experienced fear, anxiety, and depression on a permanent basis; is that correct?
A Yes.
Q Can you tell me what that is based upon?
A What my opinion is based upon?
Q Exactly.
A Yes.
Q What's the basis for that opinion?

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A The basis for that opinion is my review of her medical records and the depositions of her treating physicians.
Q Have you reviewed any medical records relating to any psychological issues that she experienced before having Prolift®?
MR. SLATER: Objection to the form of the question.
You can answer.
THE WITNESS: Could you repeat the question, please?
BY MS. JONES:
Q Have you reviewed any records relating to Mrs. Gross' psychological condition prior to the Prolift® surgery?
A Yes.
Q What?
A Well, for example, when she had her surgery in 2001, the hysterectomy and Burch procedure, she experienced headaches that were spinal headaches, and she had a prolonged course with that that was very distressing to her.
Q Anything else?
A Not that I can recall right now.
Q Let me turn to Ms. Wicker for a second.

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Can you tell me, Doctor, if Ms. Wicker had presented to you in 2008 when she saw Dr. Bercik, what treatment, if any, you would have recommended for her?

A As we discussed before, I would counsel her regarding behavioral and lifestyle changes, pelvic muscle exercises, pessary use, or surgery. Considering her duration of symptoms was relatively short, I would want to get a better sense from her as to the severity and the impact of her symptoms on her life as we discussed the different treatment options.

After that discussion, if she felt that she would like to proceed with surgery, I would discuss with her the options, with or without a hysterectomy, of apical suspensions such as the uterosacral ligament suspension and the anterior colporrhaphy for her anterior vaginal prolapse.

Q And do you feel that those surgical procedures would have been appropriate for her condition based upon your review of the medical records?

A Yes.

Q Would you have recommended surgery to her for her condition?

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A Well, again, I would want to get a better sense from her -- as I'm sure you can understand, what gets recorded in the medical record is a shorthand for what actually goes on in the counseling session. So what's not present in the medical record are -- is a high level of detail regarding her symptomatic state, the duration of her symptoms, their intensity, her degree of bother related to her symptoms, her impact on her quality of life, and so on. So before I could say with certainty that I would recommend surgery for her, I would need that additional information.

Q Do I understand then that based upon your review of the medical records you can't say one way or another whether or not the surgery was appropriate for her?

MR. SLATER: Objection.

You can answer.

THE WITNESS: Dr. Bercik is an experienced respected surgeon. I am not going to disagree with his decision after he counseled Mrs. Wicker to recommend surgery to her.

BY MS. JONES:

Q Do you know Dr. Bercik?

A No.

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Q What do you know about him?

A I know he is the head of urogynecology at Yale. I can't remember anything else specific.

Q You've already told us that you spoke with Dr. Elliott about whether or not Ms. Wicker suffered from interstitial cystitis I believe?

A I certainly spoke with Dr. Elliott. I don't remember specifically exactly what we discussed about Mrs. Wicker.

Q Did Ms. Wicker suffer from interstitial cystitis in your judgment?

MR. SLATER: Objection to the form of the question.

THE WITNESS: That is in her medical history so I would accept her historical report of that, yes.

BY MS. JONES:

Q Have you attempted to evaluate whether or not there was any other source of pelvic pain for Ms. Wicker other than what you attribute to Prolift® or the Prolift® surgery?

A Well, at this point Mrs. Wicker also has an element of pelvic muscle spasm which is likely related to her pain, which is due to the Prolift® procedure. Other than that, I don't know that she

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has any other diagnoses in her pelvis that would account for her symptoms.

Q Pelvic muscle spasms can certainly occur in the absence of the presence of mesh, can't they?

A Yes.

Q Did you review Mrs. Wicker's medical records for other physical conditions that could account for or contribute to her source of pelvic pain or her pelvic pain?

A Yes, I reviewed her records.

Q Did you identify in reviewing the records any other physical conditions that would account for or contribute to her pelvic pain?

A No, I did not.

Q Based upon your review of the medical records, was there anything in the medical records that should have served as a contraindication to the surgery, the Prolift® surgery, in Ms. Wicker?

A Now there is an understanding that patients with preexisting pain conditions like migraine headaches and interstitial cystitis are contraindicated to undergoing the Prolift® procedure because they have a higher risk of exacerbation of their current condition or the development of a new condition. That information, although known and

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foreseeable by Ethicon, had not been distributed or communicated by Ethicon to physicians and patients.
Q Other than Ms. Wicker's interstitial cystitis, what conditions did you see in the medical records that suggested that Ms. Wicker suffered from any type of chronic pain syndrome?
A Migraine headaches.
Q Anything else?
A Arthritis.
Q And where was the arthritis?
A In her hips.
Q Anything else?
A No.
Q Was there anything about what you learned from the medical records or the depositions in the case about Ms. Wicker's activities that would have contributed to her chronic pain?
A No.
Q What is your prognosis as we sit here today for Ms. Wicker?
A She carries a lifelong risk of further mesh erosions and requirement -- and the required treatment. She has recurrent prolapse that may or may not be correctable, treatable. She may not be able to undergo surgery for that because of

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complications from the Prolift®. She has pelvic pain and vaginal pain that more than likely than not is a permanent condition. This affects her ability to have normal sexual relations with her husband in that she has an anatomic vaginal canal, but the dysfunction of the vaginal tissues and the pelvic muscles and the scarring and the fibrosis prevent her from having a normal enjoyable sexual life with her husband.
Q Let me follow up with some questions on that. First, what surgery, if any, would you recommend be considered for Ms. Wicker to correct her prolapse?
A That is a very difficult question to answer that Dr. Raz is currently struggling with. She has lost so much of her normal vaginal tissue because of the scarring and the recurrent mesh erosion and the recurrent -- repeated surgeries. I've certainly never faced a situation like that in my clinical experience, so her surgical options in terms of treating her cystocele would have to be very creative.
(Discussion off the record.)
BY MS. JONES:
Q Am I correct, Doctor, that Dr. Raz

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reported that he had restored the length of the vagina to I want to say 10 centimeters? Does that sound right?
A Yes.
Q And that Dr. Raz thought he had a good result with that?
A He had a good result in terms of, as I said, the creation of an anatomic vaginal canal. He was unable to obviously turn back time and give her normal vaginal tissue, vaginal tissue in the absence of fibrosis and scarring and mesh fragments that will continue to pose a risk of recurrent mesh erosion and the need for further surgery and functional aspects of her sexual function in terms of pain, vaginal pain, pelvic pain, pelvic muscle spasm that unfortunately he is also unable to reverse.
Q And upon what do you rely that she has residual mesh?
A The ultrasound identification of mesh and the fact that she continues to present with recurrent mesh erosion.
Q And when was she last treated for mesh erosion of which you're aware?
A In October she had granulation tissue,

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which in the presence of mesh is often a precursor to the exposure. The last time --
Q October of this year?
A Yes. And that was treated in the office.
Q Was any mesh specifically noted at that time?
A She did not have an overt mesh erosion.
Q Who saw the granulation tissue?
A Dr. Raz.
Q And how was she treated for the granulation tissue at that time?
A She was treated with a topical cautery agent, silver nitrate.
Q And do you know how she responded to that?
A I do not.
Q Do you know whether or not Ms. Wicker is on any pain medication at this time?
A I do not know that off the top of my head.
Q Do you know or have an opinion as to whether Ms. Wicker would benefit from a pain management course?
A I don't know. She may; she may not.
Q If she were your patient, would you recommend that she receive treatment for pain management?

A And by that -- what do you mean specifically by "pain management"? She is having pain management.
Q Based upon what you know of Ms. Wicker's current condition, if she came to see you and you examined her, what would you recommend for her, if anything, in terms of pain management?
A You mean different or in addition to what she is currently receiving?
Q Or the same as what she's currently receiving.
A Well, she's having physical therapy. She is treated with a muscle relaxant for her pelvic muscle spasm. She is using vaginal estrogen cream to -- in an attempt to help the vaginal tissue. She's waiting to see if her vaginal tissue -- she's waiting to see if enough time can elapse without another mesh erosion for the consideration of treatment of her cystocele. I don't think I have anything to add to that.
Q Other than the interstitial cystitis and the migraine headaches, is there anything significant in Ms. Wicker's preexisting medical history that's important to you in terms of your opinions?

A I consider arthritis as another chronic pain condition that she has.
Q Anything else?
A No.
Q Do you know what the cause or do you have an opinion of what the cause of Ms. Wicker's prolapse was?
A Well, as I think we discussed previously, the etiology of prolapse is not fully understood. She has some of the epidemiologic risk factors that have been identified, such as vaginal births. Other than those factors, I don't see anything in her history that stands out in particular.
Q Do you have an opinion as to what the cause of Ms. Wicker's interstitial cystitis was?
A Even less so is the etiology of interstitial cystitis understood. And as I mentioned before, it's really just a constellation of symptoms. So, no, I do not have an understanding of what the cause of Mrs. Wicker's interstitial cystitis is.
Q And I think you told us that rather than treating a patient with interstitial cystitis, you would have referred them to a urologist for recommendations for treatment?

A Correct.
Is this a good time for a break?
MS. JONES: We can. I'm trying to finish. But if you want to take a break, we will.
THE WITNESS: Yes.
(Short recess.)
BY MS. JONES:
Q Doctor, have you seen any of the pathology on Ms. Wicker?
A Yes.
Q What did you see?
A Photomicrographs of resected tissue and mesh. And I have seen photographs of resected tissue and mesh.
Q And from whom did those photomicrographs come?
A From Dr. Welch.
Q And from whom did you obtain copies of the photographs?
A From Dr. Raz.
Q You reviewed the records relating to Dr. Raz' surgery on Ms. Wicker?
A Correct.
Q Had you ever seen anyone perform a surgery using the materials that Dr. Raz used in the

surgery?
A In -- you're referring to any of his surgeries?
Q Well, you know that he -- these are my words, not his words, but did a construct using polypropylene? Are you aware of that?
A The Prolene® suture --
Q Yes.
A -- is that what you're referring to? Yes.
Q You know that Prolene® suture is polypropylene?
A Correct.
Q Had you ever seen anyone use that before?
A No.
Q That's not something that you saw or used or trained on when you were practicing?
A Correct.
Q Do you have an opinion as to what the risks, if any, were or are with that procedure using that material?
A Above and beyond or different from the risks that we've already talked about in terms of surgery?
Q Associated with the use of that Prolene® suture as he did.

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A It would be possible to have a suture erosion or an uncovering of the suture by -- through or under the vaginal epithelium. That's the only additional risk that I can think of, you know, besides all the other things we've talked about.
Q How would you have counseled your patient on the use of that material in a way different from the use of mesh?
A If a suture erosion occurred, I would counsel the patient that that is a simple problem to solve in that the suture can be simply snipped out. It doesn't involve a dissection. It doesn't involve the likelihood of recurrent mesh erosion. And in general it would be just a much simpler procedure than resecting mesh.
Q As I understand it, Dr. Raz' surgery involved a series of interlocking sutures; is that your understanding?
A Yes.
Q Have you ever seen any published article on that procedure anywhere using interlocking sutures?
A Not that I can recall. I haven't specifically looked for it.
Q You're not aware of any randomized

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controlled clinical trial using that procedure and those materials?
A No.
Q If you had been counseling a patient, would you have suggested to the patient that that would be an experimental therapy?
A Well, as we've already established, I have not been trained in using this procedure. It would depend on what the collective experience had been with that procedure.
Q Well, I guess my question, Doctor, is knowing what you know today about that procedure and the absence of information about that procedure in the medical literature, would you have counseled or told your patients that it was an experimental procedure?
MR. SLATER: Objection to the form of the question; foundation also.
You can answer.
THE WITNESS: I'll create two scenarios for you. One scenario, let's pretend I'm a fellow with Dr. Raz and I spend three years training with him and I gain from his experience and skill in teaching and his experience in the performance of this particular procedure with his

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patients and his understanding of the risks and benefits. In that case I would not consider it experimental.
In the other scenario, I learn about this procedure in some way and I decide I'm going to try it on my patient. In that case it would be experimental and I would counsel her in that way.
BY MS. JONES:
Q Do you know whether or not Dr. Raz had performed this same procedure previously?
A I do not know.
Q Have you seen any of the radiology in this case?
A In Dr. Raz' deposition, images of the ultrasound and MRI were used as exhibits.
Q But have you seen those?
A Yes. His deposition was videotaped so, yes, I have seen those.
Q I mean did you just see it on the screen on the videotape or do you have digitalized versions of those materials?
A The former.
Q So you actually watched the video and saw those displayed on the screen?
A Correct.

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Q You've not looked at them otherwise where you were actually holding them in your hand?
A Correct.
Q You state in your report that you believe that Ms. Wicker has permanent impairment. Can you tell me what the basis of that opinion is?
A Yes. First I'd like to mention something that I forgot which is relevant to your question, and that is her urinary tract symptoms, which is frequency, urgency, and bladder pain. I believe those symptoms are permanent subject to the management that she's currently receiving.
Q Let me ask you that. Did she suffer those symptoms before she had her Prolift® surgery?
A To my understanding, her symptoms related to her history of interstitial cystitis were stable, so she did not have current symptoms related to her history of interstitial cystitis before her Prolift® surgery.
Q Had she had the same symptoms in the past --
A I don't believe she --
Q -- associated with interstitial cystitis?
A Excuse me. I don't believe she had bladder pain. I believe she had frequency/urgency

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that led to her historical diagnosis of interstitial cystitis.
Q Now, I think you were answering the question of permanent impairment.
A Yes. So her other conditions, her vaginal pain and dyspareunia, I believe those are permanent conditions. Her pelvic muscle spasm contributing to her pelvic pain is undergoing treatment with physical therapy and muscle relaxants. It's possible she may experience some improvement in those symptoms. I am not hopeful that she will experience true resolution.
Q When you're talking about she may experience some improvement in those symptoms, would that be improvement in the symptoms of pelvic spasms and dyspareunia?
A Correct, and vaginal pain.
Q And vaginal pain.
A She has symptoms related to her cystocele. And as I mentioned before, she's waiting -- she and Dr. Raz are waiting to see if a sufficient amount of time will elapse for him to be confident or relatively confident that mesh erosion will not recur and that he may be able to proceed with the cystocele repair. If he judges that he cannot, then

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her cystocele will be a permanent condition. She continues to be at risk for recurrent mesh erosion and the risks associated with her treatment, which would be surgical.
Q I'm sorry. You said the risk associated with her treatment would be?
A Surgical.
Q Would be the risk associated with surgery, is that what --
A That's what I intended to mean.
Q I'm sorry. I just didn't understand.
You say in your report that Ms. Wicker is disabled. Can you tell me the basis of your opinion that she is disabled?
A She is disabled to the extent that she can't enjoy a normal sexual life with her husband. She is disabled to the extent that she is troubled by chronic pain and all of the consequences that attend that. She is disabled to the extent related to her urinary symptoms with frequency and urgency and bladder pain that induce anxiety and worry that she will have an incontinent episode in public, for example, and face the humiliation of that if she can't reach a restroom in time. And those conditions, her urinary symptoms, I believe are

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permanent.
Q Can I just ask one question? I asked you first about permanent impairment and then I asked you secondly about disability.
A Yes.
Q And I'm trying to discern whether or not those are one and the same or they're two different issues. Let me just say if I'm reading this, I look at disability as saying disability in the sense of being unable to participate, for example, in gainful employment or the normal activities to which she has been engaged in. Is that what you're --
A Well --
Q Is that how you would define it, first?
MR. SLATER: Objection.
You can answer.
THE WITNESS: I would take a broader view of disability affecting every minute of every hour of every day of her life. And that includes, as I said, being disabled in her ability to enjoy normal sexual relations with her husband, being disabled in terms of limitations on her activities based on her frequency, urgency, and bladder pain and the necessary proximity of a restroom and her pelvic pain in general and, as I said, the

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consequences that attend chronic pain and the disability that inflicts on her quality of life.
BY MS. JONES:
Q If you were her doctor, based upon what you understand her current condition to be, would you restrict her activities in any way?
A In my opinion, the harm has been done. The harm was done when she had the Prolift® procedure and the permanent Prolift® mesh implantation. I don't believe she can further harm herself by engaging in the activities that provide her with a semblance of the quality of life that she had before.
Q So the answer is that you would not restrict her activities in any way today?
A I would restrict her activities to her tolerance of her symptoms.
Q Can you switch back to Ms. Gross for a second?
A I can.
Q Would you put any restrictions or limitations on Ms. Gross and her activities if you saw her today?
A Again, the harm has been done with the Prolift® procedure and the permanent Prolift® mesh

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implantation. I don't believe she can further harm herself with her activities. And, again, if -- the restrictions would be only to the -- her tolerance of her symptoms such that she doesn't precipitate a level of pain that's intolerable to her.

MS. JONES: Did someone join us on the phone?

MR. SLATER: I think that was the sound of someone hanging up actually.

MS. JONES: I think it was, too. That's what I was checking.

MR. CAMERON: This is Roger. I think it was just a line check.

MS. JONES: Dr. Weber, I thank you. I think that's all I have right now.

MR. SLATER: I have a couple brief follow-up questions. I'll only be three or four hours.

BY MR. SLATER:

Q A few moments ago in the context of Pam Wicker you were asked about the symptoms of her cystocele, her bladder prolapse that she currently has. Remember that?

A Yes.

Q And within the constellation of symptoms

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or the results of her cystocele, is one of those results obstructed voiding?

A Yes.

Q And that was discussed by Dr. Raz as well during his testimony; correct?

A Yes.

Q And what is the obstructed voiding and why is that due to this recurrent prolapse that has occurred since all these surgeries had to be done after the Prolift®?

A What happens with a cystocele, when the bladder drops down, there's a kinking effect between the urethra and the bladder so that it becomes very difficult for the bladder to empty normally. And, in fact, Mrs. Wicker is in the very uncomfortable position of having to stand in order to be able to empty her bladder to try to overcome this obstructed voiding.

Q Do you believe as long as the cystocele is not able to be repaired that that will continue?

A Yes.

Q You were asked a question a moment ago about Linda Gross and whether her activities would be restricted by you. Remember that question?

A Yes.

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Q Do you have an understanding of the fact that due to her condition, Linda Gross is unable to conduct her normal daily activities and to work; correct?

A Yes.

Q And that's a result of her condition?

A Yes.

Q It also affects her ability to engage in her day-to-day activities that she would prefer to engage in?

A Yes.

Q You were asked earlier about Dr. Minkin's report about Linda Gross. In her report Dr. Minkin talked about the episode in 2001 where Linda Gross suffered from spinal headaches and it took about a year for those to resolve. You saw that?

A Yes.

Q And you saw where Dr. Minkin actually referred to those as migraines? Did you see that?

A Yes.

Q In the context of what you've testified to earlier with regard to chronic pain as a contraindication and in the context of Dr. Benson's overall testimony, how does that fit in if, in fact, one were to consider that to be a chronic pain or

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migraine condition? How would that impact on your overall opinion?

A Yes. Well, as we discussed previously, what has been learned by surgeons over time is that patients with a preexisting pain condition are at much higher risk for either the exacerbation of their existing pain condition or the development of a new pain condition after the Prolift® procedure such that it is considered -- the Prolift® procedure is considered now contraindicated in those patients. So given the fact that Mrs. Gross has this history, then that would have served as a contraindication for her to undergo the Prolift® procedure at all.

Q With regard to a comparison of risks between certain native tissue repairs with sutures and the Prolift®, you were asked about various risks. Remember that mostly yesterday and a little today?

A Yes.

Q Is there a significant difference between the severity, the duration, and the treatability of pain with intercourse or discomfort with intercourse that a woman might experience after a native tissue repair as compared to the dyspareunia that a woman could suffer following a Prolift®?

A Yes. There --
Q I don't need you to explain. I just want to establish that.
A Okay.
Q Counsel obviously can ask you about it, but I just want to make sure it's clear. I know it's explained in your report.
Earlier in the deposition you testified with regard to what you termed as Ethicon's deception to surgeons at the time that Linda Gross and Pam Wicker had the procedure. Remember that testimony?
A Yes.
Q And in the course of your reports, did you detail your evaluation of the different things that you would term Ethicon's deception of surgeons beginning with the launch up through those surgeries?
A Yes.
Q One thing that you talked about was the failure of Ethicon to obtain 510(k) clearance. Are there other aspects to Ethicon's deception beyond their failure to tell doctors that the product had not been cleared by the FDA?
A Yes.

Q You talked earlier in the deposition about your reliance on certain physicians with regard to the fact that the Prolift® mesh can harbor a chronic low-grade infection which can cause recurrent erosions and other harm to a woman. Remember that testimony?
A Yes.
Q And you said that two of the physicians you relied on were Dr. Raz and you referred to the doctor from Connecticut. That would be Dr. Kreutzer?
A Yes.
Q Did you also rely on the opinions and experience of Dr. Margolis as well in that regard?
A Yes.
Q You were asked if you had spoken with any Prolift® users about the Prolift® or the Prolift® professional education. Do you remember that?
A Yes.
Q You did, in fact, have the ability and you did actually read the depositions of Dr. Benson, Dr. Bercik, Dr. Raders, Dr. Hinoul, Dr. Robinson, Dr. Kirkemo, Dr. Jafri from the Firman case, you had the opportunity to read extensive deposition testimony from multiple users of the Prolift® in

that context; correct?
A Yes.
Q You were asked about the summary of medical records that was provided to you by my office and I think you said one or more deposition summaries. Ultimately, beyond just using those as a short summary of what had been provided just to get an idea of what was there, did you ultimately read each of the records yourself and read each of the depositions yourself and rely on your own reading of the source materials to form your opinions?
A Yes.
MR. SLATER: I have no other questions.
BY MS. JONES:
Q Let me follow up just briefly, Doctor. You were asked about dyspareunia following the use of transvaginal mesh. Have you actually treated a woman who has had transvaginal mesh implanted for prolapse for dyspareunia?
A No.
Q You were asked about the obstructed voiding that you say Ms. Wicker is experiencing?
A Yes.
Q Is that something that could be treated

with the use of a Burch procedure?
MR. SLATER: You're asking specifically in Pam Wicker as things stand now?
THE WITNESS: The Burch colposuspension is indicated for the treatment of stress incontinence. It is not indicated to resolve obstructed voiding.
BY MS. JONES:
Q Do you know whether or not the use of that procedure could be used for obstructed voiding in Ms. Wicker?
A Well, of course, it could be. I wouldn't recommend it.
Q Do you know whether or not the TVT® procedure is available for use in obstructed voiding?
A No.
MS. JONES: That's all I have.
BY MR. SLATER:
Q Just to follow up on those last two questions, when you said Burch could be used, were you saying that you would recommend it or think it's an appropriate treatment for Pam Wicker?
A No. I was just responding in the general sense that anybody can do anything, but I would not

recommend it.
Q The problems that Dr. Raz testified with regard to during his trial testimony, those would apply to any effort to treat the cystocele at this point; correct?
A Yes.
MR. SLATER: No other questions.
(Witness excused.)
(Whereupon the deposition adjourned at 4:47 p.m.)
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CERTIFICATE

I, KIMBERLY A. OVERWISE, a Certified Court Reporter and Notary Public of the State of New Jersey, do hereby certify that prior to the commencement of the examination, ANNE M. WEBER, M.D., M.S., was duly sworn by me to testify to the truth, the whole truth and nothing but the truth.

I DO FURTHER CERTIFY that the foregoing is a verbatim transcript of the testimony as taken stenographically by and before me at the time, place and on the date hereinbefore set forth, to the best of my ability.

I DO FURTHER CERTIFY that I am neither a relative nor employee nor attorney nor counsel of any of the parties to this action, and that I am neither a relative nor employee of such attorney or counsel, and that I am not financially interested in this action.

KIMBERLY A. OVERWISE
CCR: 30X100224600
Dated: November 19, 2012

INSTRUCTIONS TO WITNESS

Please read your deposition over carefully and make any necessary corrections. You should state the reason in the appropriate space on the errata sheet for any corrections that are made.
After doing so, please sign the errata sheet and date it.
You are signing same subject to the changes you have noted on the errata sheet, which will be attached to your deposition.
It is imperative that you return the original errata sheet to the deposing attorney within thirty (30) days of receipt of the deposition transcript by you. If you fail to do so, the deposition transcript may be deemed to be accurate and may be used in court.

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ACKNOWLEDGMENT OF DEPONENT

I, ANNE M. WEBER, M.D., M.S., do hereby certify that I have read the foregoing pages, 213-385, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

________________________ ___________

ANNE M. WEBER, M.D., M.S. DATE

Subscribed and sworn
to before me this
____ day of __________, 2012.

My commission expires:______________

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Notary Public

LAWYER'S NOTES

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